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ORIGINAL ARTICLES.

Inflammations About the Caput Coli.*

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It is with some hesitation that I have selected a title of so general a character for the paper which I have the honor of presenting to this society. It has come to pass in the case of inflammation in the vicinity of the colon that most of our writers are attributing all of the inflammatory affections in this region to pathological conditions of the appendix. The reason for this is not far to seek. Most of the recent work that has been done upon this subject has been done by operating surgeons, especially those of abdominal tendencies. These operators are necessarily brought in contact with the more serious cases of inflammation about the caput coli, i. e., those in which pus has either formed or will inevitably do so within a short time, and it must be confessed that in these cases the appendix is most often at fault. The general practitioner comes in contact with both classes of cases, those in which the operation is required, and those in which recovery occurs without surgical intervention. The surgeon, who is most frequently called in only when an operation is inevitable, necessarily looks upon the subject with an operative bias, and is apt to say without qualification, that all cases of inflammation about the caput coli require operation. If on the other hand, the general practitioner has a run of cases in which recoveries without operation preponderate, which is very often the case, he is apt to assume an ultra-conservative position. I have heard surgeons support the operative treatment of these cases in most radical terms, without the least qualification or the slightest attempt at differentiation of cases and conditions. On the other hand, I have heard practitioners of experience assert that operation is never indicated, and that conservative treatment should be adopted as a matter of routine. For example, I heard a practitioner of many years experience, state at an important society meeting, that the free administration of opium and the faithful application of hot poultices was the only treatment which was warrantable in cases of this kind. In support of this position, he stated that his father before him had treated such cases in a similar manner and with success, and that he hoped that his son, who was to follow him in his practice, would also treat them in that way. It was rather painful to note this addition to our list of hereditary fatalities, and it would, I presume, have been a hopeless task to convince this old gentleman that certain cases of peritonitis of a fatal character, which had occurred in his practice, were due to undiscovered or neglected peri-typhlitic abscesses.

With regard to the statistics compiled with a view of determining the relative value of conservative and operative measures, it is probable that we will always experience extreme difficulty in forming a positive opinion. The surgeon reports a long list of cases, showing the brilliant successes attendant upon operative measures, without the least attempt at discrimination as regards the relative gravity of his cases. Not all surgeons are open to criticism in this respect, it is true, but unfortunately we are compelled to rely for our statistics, not upon the cases of a few experts, but upon the cases of a large number of practitioners, many of whom may be classed as average surgeons, whose opportunities for the post-mortem verification of diagnoses and for the comparison of a large number of cases are rather limited. Some reports are based mainly upon cases of operation, the gravity of which is no greater—as far as the operation *per se* is concerned—than that of opening an ordinary abscess. Other reports are based upon cases requiring active interference with the caput coli and resection of the appendix. In other instances, the surgeon is not appealed to until rupture and infection of the general peritoneal cavity has occurred. Necessarily there is in such cases a very meager prospect of cure by operation, yet such cases are accredited—and I think unfairly—to the sum total of operations for perityphlitic abscess, or appendicitis, if you please. I think that the necessity for a careful differentiation of cases in order to enable us to come to a rational conclusion as to the comparative value of radical or conservative measures is at once apparent. I believe, moreover, that the conservative practitioner and the abdominal surgeon should not work upon parallel lines, as seems to be the tendency, but upon those which converge to logical conclusions of the advisability of occupying a middle ground in the controversy. The surgeon is a potential force for the accomplishment of greatly needed work in cases of inflammation about the caput coli. He often, however, is more efficient for good when he brings the experience of the level-headed, conservative, general clinician to his assistance. A series of successful cases under conservative measures by no means proves that a routine conservatism is best in such cases, neither does an occasional case dying without operation, when every expert surgeon knows that an operation may have saved life, prove that operation is always indicated.

Nowhere has modern surgery been characterized by more signal triumphs than in the pathological study, diagnosis and treatment of inflammations about the head of the colon. This great advance in our knowledge and surgical resources is to be attributed to the arduous labors of American physicians and surgeons, among whom Sands, Weir, Morton, Hoffman, Fitz, Pepper, McBurney, Dennis, and Stimson are especially prominent. The papers of Dr. McMurtry, of Louisville, and Drs. Murphy and Lee, of Chicago, have been important contributions to the subject.

It was long believed that inflammation of the cellular tissue about the colon was the main factor in peri-typhlitic inflammation. Modern pathologists and abdominal surgeons have disproved this theory as far as its general applicability is concerned, and have attempted to show that a diseased appendix is the *fons origo et mali* in practically all of these cases, abjuring the cellular tissue altogether, and seeming to believe

*Read at the meeting of the Mississippi Valley Medical Association, Oct. 15, 1892.

that by some peculiar dispensation of Providence, cellular tissue in this location is protected from those causes of inflammation and suppuration which are potent elsewhere. This, it would appear, is an extreme view, and one which bids fair to work sad havoc with the luckless appendix. It has even been facetiously suggested that the only salvation for the human race is a prophylactic excision of the appendix as soon after birth as practicable. Whether this would result some generations hence in an appendixless type of men is a question, but if rats may be bred without tails, I suppose such a result will not be too visionary for consideration if the present furor of excitement over the appendix keeps up. Like Davy Crockett after the coon, when the enthusiastic surgeon starts after the appendix he is bound to get it. It remains to be seen what he will do when the appendix becomes obsolete. Much as we may deplore surgical radicalism, the female ovary has had much to be thankful for since the attention of the abdominal surgeon has been directed to the appendix.

Regarding the relation of the cellular tissue to abscesses about the colon, while it is undoubtedly true that in the majority of cases it bears the same relation to inflammation, and perhaps perforation of the appendix, that so-called pelvic cellulitis bears to pathological conditions affecting the uterine appendages, and is of a purely secondary nature, it should, I think, be assigned a little more important role than most abdominal surgeons believe. It would certainly seem to be true that in many cases of perityphlitic inflammation, involvement of Velpeau's membrane—the extra-peritoneal cellular tissue—has much to do with the peculiarities of the resulting abscess. This is especially true of retro-cæcal abscesses. A point which seems to me of some importance and which was brought out in a very positive manner by my friend, Dr. McMurtry, of Louisville, in a paper before the Southern Surgical and Gynæcological Association, in 1891, is the arbitrary assertion that the inflammatory process and resulting abscess in cases of inflammation about the caput coli are always intra-peritoneal. This assertion is based upon the recent anatomical dissections of Treves, Bull, and others, which seem to show that the appendix and cæcum are wholly within the peritoneal cavity. It has also been shown by such operators as McBurney and others, that the abscesses are usually intra-peritoneal. This assertion requires qualification, for general practitioners will very often allow a perityphlitic abscess to rupture spontaneously, either externally—which happy event occasionally occurs—into the cæcum, or with an almost enevitably fatal result, into the peritoneal cavity, because of the horror which men of small experience in abdominal operations have of the peritoneum. In other cases the abscess will be allowed to burrow in various directions and finally to appear at some point far distant from the original focus of suppuration. These disagreeable results are permitted in the face of the fact that a simple incision into what is practically an ordinary abscess would prevent them. A pointing perityphlitic abscess—intra-peritoneal though it may literally be—is practically extra-peritoneal because of the barrier of lymph, young connective tissue, and agglutinated intestine that shuts it off from the general peritoneal cavity. This point I believe to be of paramount importance. In some cases it would appear that the inflammation may agglutinate the peritoneum about the appendix, and form an abscess of small size which perforates through into the retro-peritoneal cellular tissue. This appears to me to be the explanation of the tardiness with which some abscesses in this location come to the surface. Instead of the induration being at once manifest it may be some days or weeks before it can be detected with any degree of positiveness. The abscess meanwhile burrows along the planes of cellular tissue in the iliac fossa to the ilio-lumbar region and may appear at some distance from the head of the colon, or may gradually burrow outward toward the loin and downward, and upward in the direction of the groin until at one or both points it becomes perceptible to the touch. In several cases in which I have operated, I have every reason to believe from the conditions present that the process was extra-peritoneal, and that the abscess had burrowed up in the direction of the kidney as well as downward into the iliac fossa. The point which I wish to emphasize is, that even though these abscesses be considered *ab initio* intra-peritoneal, the operator must not lose sight of the fact that in some cases he can do what is practically an extra-peritoneal operation, for there is at least a barrier produced by adhesions which shuts off the collection of pus from the general abdominal cavity.

In view of the prominence which inflammation, gangrene and perforation of the appendix has been accorded in the etiology of suppurative processes about the caput coli it may seem rather bold to express a belief in the occurrence of such inflammatory troubles without such serious disease of the appendix. It must be admitted that such cases very often get along very well without operation, and perhaps do not even suppurate, but this should be accepted as at least a partial explanation of the arbitrary position of the surgeon. The cases in which serious disease of the appendix exists must come to suppuration and should as a rule be operated upon, while in many of those in which the appendix is not involved to a serious extent, conservative measures may succeed with the result that the surgeon has no opportunity of examining the case. I think that general practitioners of experience will be inclined to recognize cases of inflammation about the colon which do not begin in the appendix *per se*, but have for their starting point inflammation in the colon proper. I can see no reason why this inflammation may not extend to the cellular tissue outside of the colon without there being necessarily any perforation or even any suppuration. This extension of inflammation, I believe, does occur and in all likelihood is the result of infection. A comparative study of the bacterium coli commune and pyogenic microbes may in the future shed some light upon this subject. The close similarity or, as is claimed by some, identity of the two forms of microbe is suggestive to say the least.

Whether inflammatory conditions in and about the appendix and colon may give rise to evolutionary changes in the bacterium coli commune by which it acquires properties of infection and pyogenesis, is at least an open question, and one upon which the bacteriologist is alone competent to pass an opinion.

The relation of foreign bodies to appendicitis and the pathological processes secondary thereto, might be considered to be quite definitely settled were it not for the fact that every now and then contributions to medical literature appear in which foreign bodies

are assigned a very unimportant place in the etiology of the disease. Within a year I have heard a prominent abdominal surgeon state, that in his opinion foreign bodies were very rarely the cause of inflammation and perforation of the appendix with resulting abscess, he citing a number of cases in which he had evacuated large abscesses in this situation and had removed the appendix, and had been unable to detect a foreign body of any kind. I was not convinced on listening to this gentleman's description of the cases that they conclusively proved that foreign bodies were not present even in them. A foreign body of very small proportion is doubtfully sufficient to cause appendicitis, and it is conceivable that the finer fruit seeds and even foreign bodies of a larger size might easily be overlooked in the cavity of the abscess or the pus which discharges therefrom. The foreign body is, as is well known, not necessarily of extraneous origin. It is probable that in some cases of appendicitis a catarrhal colitis is the point of departure for the pathological process. Obstinate constipation may lead to a catarrh of the colon, which process extends to the appendix with a resulting slight swelling of the appendico-cæcal opening. The resulting formation of a fæcal stone is so well known that I would not repeat it, were it not necessary to a complete presentation of the subject. Mucus collects in the appendix, a small amount of the fæcal matter gets into the tube during straining at stool, and fails to get out again, and forms in combination with the mucus a small fæcal stone. Sometimes this fæcal stone is formed in the cæcum and is forced into the appendix, although it is probably most often formed in the appendix proper. A practical point in this connection, to which I believe attention has not been called, or at least if so, it has not been brought to my attention, is that in certain cases of inactivity of the colon with resulting constipation and catarrhal colitis; abdominal massage, which is so frequently recommended and which is so often beneficial in constipation, is apt to be a source of danger. A small portion of fæcal matter may be forced through the partially stenosed appendico-cæcal opening, and once imprisoned in the appendix it will become as truly a foreign body as though it were of extraneous origin. The fæcal stone may set up a varying degree of inflammation of the appendix according to the degree of distension of the little tube. Frequently, as is well known, it perforates and produces inflammation and suppuration about the head of the colon. It is probable that in some cases the fæcal stone dissolves in the resulting pus formation, and this would seem to be the explanation of many of those cases in which perforative ulceration of the appendix is found and yet no foreign body is discernible in the pus sac. It is not impossible that in every case where perforation occurs there has been a foreign body of some kind. Many cases of appendicitis remain catarrhal, and may cause little or no disturbance of the patient's health. The frequency of this condition is well shown by Fitz in his analysis of seventy-two cases in which appendicitis was probably not suspected during life.

With regard to the dependence of appendicitis upon foreign bodies, a very interesting case was reported by my friend Dr. C. A. L. Reed, of Cincinnati, in the Transactions of the Southern Surgical and Gynæcological Association for 1890. He was called to see a fine, stalwart woman, who had been troubled with constipation, for the relief of which she had taken a regular diet of compound cathartic pills. She had suffered for two weeks with inflammation about the caput coli, the diagnosis of which was indisputable. Laparotomy disclosed a very large pus cavity. This was opened and irrigated: the appendix had disappeared, and in the cavity of the abscess were found half a dozen of the compound cathartic pills.

While I am speaking of the relation of foreign bodies to appendicitis, some members of this society are doubtless recalling cases, either personal or reported in the journals, in which perforation, gangrene, and perhaps spontaneous amputation of the appendix has occurred, yet no foreign body has been discoverable. It might not be amiss in this connection to again suggest the readiness with which a foreign body may be overlooked and the possibility of a fæcal stone dissolving in the resulting pus. No one has yet made clear the reason for such an intense inflammation affecting a structure anatomically and functionally so unimportant as the appendix vermiformis. Leaving out of consideration some special type of infection or the impaction of foreign bodies, such pathological processes, to say the least, are difficult of explanation.

Causes.—The causes of inflammation in and about the head of the colon may be summed up as:

1. Fæcal impaction.
2. Fæcal stone.
3. Extension of catarrhal colitis with occlusion of the mouth of the appendix.
4. Foreign bodies of extraneous origin.
5. A possible primary infection of the appendix and the tissues about it by pus microbes.
6. Traumatism.

The latter cause may be disputed but I have observed one case in which it appeared to be the starting point of the disease. It is not difficult to appreciate the possible importance of traumatism. A blow upon the abdomen over the distended colon might, it seems to me, give rise to a bruising of the colon with resulting inflammation, which may extend to the appendix and the retroperitoneal cellular tissue, or may cause extrusion of fæcal matter into the appendix with resulting fæcal stone and its sequelæ. The relation of fæcal impaction in the colon to perityphlitic abscess is possibly more important than is generally believed. In two cases of my own in which an abscess resulted, and in which I performed an operation, there had been no constipation before or during the patient's illness, yet some days after the operation a large fæcal mass descended into the rectum, and I was compelled to remove it in each instance by mechanical means. As the patient had been having a stool daily under the use of salines, the most likely point at which this fæcal mass could have formed was the caput coli. I can appreciate the possible objection that the impaction was the result rather than the cause of the inflammation.

It is a noteworthy point that perforation of the appendix results so often in a limited inflammation, while, perforation of the stomach is immediately and almost inevitably followed by a fulminant peritonitis. Mynter explains this, by the more active peristalsis of the stomach and small intestine, which results in a more speedy and liberal distribution of the infective matter over the peritoneum. The comparatively small caliber of the appendix and the slight *vis a tergo* imparted to the small quantity of fæcal matter in its

lumen, constitute a more logical explanation. Both factors are probably operative.

Experience at the bedside and autopsy table, has permitted of a tolerably definite classification of appendical inflammations. One of the best classifications is that of With, of Copenhagen, which is as follows:

1 peritonitis appendicularis, adhesiva.
2 peritonitis appendicularis, localis.
3 peritonitis appendicularis, universalis.

Diagnosis.—The diagnosis of perityphlitic abscess is confessedly not always easy, as is shown in one of my own cases in which I stood ready to operate, the symptoms pointing clearly to the existence of pus and the fullness of the ileo-cæcal region and tenderness at that point, seeming to warrant an operation. In this case the patient recovered after the passage of a large amount of fæces. Fitz reports a case of circumscribed peritonitis in the right iliac region, diagnosed as appendicitis, which was afterward proven to be on autopsy abscess of the liver due to catarrhal colitis. In a second case, diagnosed as appendicitis, the post-mortem disclosed a suppurating sub-peritoneal gland, due to gonorrhœal infection. In a third case pyosalpinx was mistaken for appendicitis. In a case of my own appendicitis existed with a small abscess, but all of the symptoms which existed prior to the operation have persisted for a long time, and were due in all probability to spinal irritation. This case was not operated on by me, but was under my care some months after the operation, and finally drifted into Dr. Senn's hands, and was, I understand, cured by spinal counter irritation. A valuable point in diagnosis in obscure cases is the fact, that when an abscess, forming about the caput coli, tends to burrow upward toward the kidney, there will be marked irritation of the psaos muscle, marked flexion of the thigh, crural neuralgia, and great pain on attempts at straightening the limb. Dr. McMurtry, in his excellent paper already alluded to gives this as one of the typical signs of appendicitis, but I have not observed it as a prominent symptom excepting in cases in which the abscess has had a tendency to burrow in the direction indicated. In these cases the diagnosis was not positively made early in the case, and this symptom came on only after the abscess had in all probability opened into the retro-cæcal cellular tissue and developed a secondary pus sac in that situation.

One of the first things that the general practitioner is likely to do when he discovers an induration characteristic of perityphlitic inflammation, is to plunge the needle of an aspirator or hypodermic syringe into the mass. I never could understand why the practitioner should do this, for as a rule he does not intend to operate when he finds pus, and the inspection of a few drops of stinking pus is not likely to give very much assistance in a diagnosis which is already clear. If pus has not formed, the induration not only does not require aspiration, but there is danger of infecting the peritoneum by the needle. If pus has formed, aspiration does no good, and there is still greater danger of infection. Very often the aspirator is relied upon as the crucial test for the diagnosis and an operation is decided against because pus is not withdrawn by the needle. As a matter of fact, however, it is difficult to get at the pus with a needle excepting in those cases in which the abscess has fortunately come forward in the direction of the anterior abdominal wall. Even in these cases, if the anterior peritoneum is not agglutinated to the abscess sac, the introduction and withdrawal of the needle may be followed by infection of the general peritoneal cavity, septic peritonitis, and death. Aspiration then may be set down as on the average dangerous and about as logical as the performance of the ostrich who seeks safety by sticking his head in the sand. If the practitioner is not secure in his diagnosis, and is not capable of doing abdominal work, he should not be deluded into a show of industry by the facility with which he can jab a needle into the induration in the iliac fossa. Are there any circumstances under which aspiration might be advisable? When the pus has come well forward and the abdominal tissues are involved in the agglutinating process of the abscess walls, and it is necessary to convince the patient or the physician in charge of the necessity of an operation by an impression upon the ocular or olfactory apparatus of the doubting Thomas, aspiration may be prayerfully considered.

One of the most important points in connection with appendicitis is that many cases of so-called idiopathic peritonitis are dependent upon a fulminant attack of appendicitis which spreads so rapidly to the general peritoneum that acute peritonitis occurs and masks the primary trouble in the right iliac region. It is probable that in many children who are said to have idiopathic peritonitis there has really occurred primarily, inflammation about the appendix. In children, however, the inflammation may extend to the sensitive peritoneum so rapidly that a fulminant peritonitis results and destroys the little patient's life long before the period of pus formation, while in the adult suppuration a distinct tumor will be observed. The more carefully these cases of peritonitis are studied, the narrower the range of idiopathic peritonitis becomes. Appendicitis and traumatism are often at the bottom of so-called idiopathic peritonitis. One of the cases which I shall shortly relate was probably an illustration of the rapidity with which the inflammatory process in the appendix will extend to the general peritoneum. Many times, perhaps, general peritonitis has been preceded for some time by inflammation of the appendix of a low grade, the symptoms of which have not been sufficiently prominent to attract attention. Suddenly, however, gangrene or perforation occurs with resulting infection of the general peritoneum, and within a few hours the patient is in the agonies of what is labeled "idiopathic peritonitis."

Should the mortality rate reported from operations for perityphlitic abscess be an arbitrary guide in deciding the question of the advisability of an operation? It would seem not. Each case should be judged upon its own merits and an occasional error in judgment should not condemn conservatism on the one hand, or operation upon the other. Operation for the results of appendicitis necessarily varies in its gravity with the condition present. Thus it may be (1) surgically extraperitoneal, albeit it may be anatomically intraperitoneal. (2) Intraperitoneal, the condition being nothing more nor less than a septic peritonitis, the operation perhaps being performed when the patient is in a desperately bad condition. (3) The appendix may require resection. (4) The operation may be no more formidable than the evacuation of an ordinary abscess, the latter being the kind of cases in which some operators have achieved

their greatest glory. (5) The appendix may be removed in the interval between the attacks of recurrent appendicitis. Obviously the mortality rate will vary greatly in these conditions. The mortality of appendicitis, as recorded up to date, is extremly severe. Fitz, who has reported more cases than any other writer, states that seventy-four per cent of cases have recovered and twenty-six per cent have died, about one-half of these cases being treated medically and the other half surgically. As McMurtry remarks, "this indicated that those treated surgically were operated upon late in the diseases," which may have meant that the patients were practically moribund. The late operation has had the enormous mortality of fifty per cent.

It is not my intention to expatiate upon the treatment of inflammation about the caput coli. There are some points, however, that will bear brief mention. It is probable that the tendency in such cases is to overdose with opium, while perhaps the objections which apply to the use of opium in general peritonitis do not apply so pertinently to the localized inflammation under consideration, it should, at the same time, be used with extreme caution. Should pain be severe, morphia hypodermically in moderate doses may be warrantable, but great care should be taken—especially in administration by the mouth—lest the digestive organs be disturbed and vomiting result, which might prove disastrous to a patient in this condition. As a rule, local applications will accomplish the desired analgesic effect. Piping hot poultices, sprinkled liberally with laudanum, are always in order. An application which has in my hands proved a desirable substitute for the internal administration of opium in abdominal affections of a painful character, is an ointment with lanolin for a base, to which is added menthol, extract of aconite, belladonna an extract of opium in considerable strength. Salines in full and frequent doses constitute, it seems to me, the only rational measure of internal medication.

Selection of Cases for Operation.—Wylie has stated that, "should the symptoms of a local peritonitis in the region of the cæcum not begin to improve by the fourth or fifth day from saline treatment and local applications over the seat of the inflammation, an incision should be made down through the muscles and the peritoneum dissected up until a place is found where the abscess is attached, when it should be opened. While the operation would be less difficult if delayed, the danger of the abscess rupturing and producing acute septic peritonitis must be borne in mind, hence an increased difficulty in doing operation is more than compensated for in the risk saved the patient."

McMurtry says: "Operation involves less danger than delay, and should be resorted to in all cases in which the high grade of inflammation is persistent." The essentials of the operative technique according to this authority are, "brief anæsthesia, quick and thorough work, removal of the appendix, irrigation and drainage." From my experience and observation of these cases, I believe that the safest guides are the pulse, temperature, degree of sensitiveness of the region involved, and the rapidity with which the induration occurs. Cases of the fulminant type, such as occurred in one of Chicago's well known citizens, and which was operated upon by Dr. McBurney a short time ago, demand an immediate operation, and should be regarded in the light of a septic peritonitis from a surgical standpoint, whether general involvement of the peritoneum has begun or not. Many cases will occur in which conservative measures are indicated, but in every such instance the attending physician should call a capable surgeon into the case in order that the operation, if indicated at all, may be done sufficiently early. In cases which are seen after fluctuation has occurred, or when there is no fluctuation but evident agglutination of the mass to the structures of the abdominal wall, or in any case in which we are reasonably certain that pus has already formed, an operation should be performed at once if the purulent collection is at all accessible. The pus should never be allowed to select its own exit, for while it may burrow in a favorable direction and open spontaneously at a favorable point, we have no assurance that it will do so, and our duty is to make a favorable point for it. A conservatism which permits an abscess in any of the great cavities of the body to knock at all the doors in the neighborhood in the attempt to find the point of least resistance with the result oftentimes of escaping at a door which opens into some of the vital structures or organs of the body, is not the kind of conservatism that is most conducive to our patient's welfare.

As for the appendix, the statement made in Dr. McMurtry's paper, that it should always be removed is probably too arbitrary. Many cases recover after the evacuation of the abscess without removal of the appendix and without subsequent recurrence of the inflammatory process. Cases recover spontaneously by discharge of the pus into the bowel or externally without recurrence of the disease. The question should be decided not in a routine manner, but according to the conditions which the affected part presents. The site of the incision in operations for the relief of appendicitis and its sequelæ has been the source of some discussion, some surgeons advocating a perpendicular incision, others one corresponding to the direction of Poupart's ligament, and still others a combination of both. It would seem that we have here another opportunity for the differentiation of cases. Where there is a palpable tumor its axis is very apt to be in the general direction of Poupart's ligament, and under such circumstances an incision as for the ligation of the external iliac is advisable. Under other circumstances it may be preferable to make a vertical incision over the caput coli, or perhaps combine the two incisions, a proceeding which is very apt to be necessary in order to expose and remove the appendix.

In presenting this general survey of inflammations about the caput coli, there has been no attempt at completeness. If I shall have succeeded in stimulating a discussion on the more important practical points involved—which points have been aptly illustrated by cases in my own experience, I shall have accomplished my object.

(*To be Continued.*)

ASCARIDES.—It is wrong, according to the late Dr. Demme (of Berne), not to believe in the disastrous consequences of the presence of ascarides lumbricoides in the digestive tract of children. They may provoke *pernicious anæmia* which sometimes ends fatally. Purgatives for the expulsion of the ascarides, followed by appropriate anthelmintics, have proved themselves efficient means in promptly averting accidents.—*Merck's Bulletin.*

Problems in the Pathology and Treatment of Inebriety or Rational Cure of the Drink Habit.*

By John G. Reed, M. D., Elmwood Place, Cincinnati, O.

Physical affinity for alcoholic stimulants is the cause of the drink habit and its frightful consequence in society. Upon the written statements of their authors the special treatments that have been used for the drink habit were concocted without a knowledge of the physical cause of it, and they have the usual unreliability of empirical treatment, as I have learned by the study of results. Drugs used in some of the so-called permanent cure treatments that I have examined are unsafe, particularly when used in the same quantities one case with another. They act to suspend appetite for alcoholic stimulants as one poison counteracts another, or by serving as a substitute in effect for alcoholic drink until nature removes from the nervous system the effect of alcohol acting as a poison. There is no alternative that is essential to the cure of alcoholism.

Definable forms of disease do not produce affinity in the sense of craving. We need to consider conditions without a known lesion or material agent of disease designated vaguely by the terms of cachexia, diathesis, constitutional habit, etc. In the sense that particular forms of disease are prevented by the treatment of constitutional disease through experimentation, we learn that shock from chemical affinities in nutrition create alcoholic affinity, and by correcting said affinities we prevent habitual drinking and its physical consequences. By urinalysis we get the chemistry of the drink habit and its disease. In answer to "social bluff," conditions of society afford no rule of general application by which we can differentiate those of drinking tendencies from others. There is evidence of the fact that species of the lower animals are divided into tipplers, drunkards, and abstainers. Intellectual fortification against stimulation through pain of intemperance, is principally due to evolved favorable conditions of energy, otherwise alcoholism would be less variable in its duration. Affinity means to drink and lack of it means to touch not the stuff that kills whether it be in prince or pauper.

Drunkenness.—Medical influence, vice, or curiosity are causes for the first voluntary drink. Conscience is affected favorably or unfavorably by it as determined by the effect the mind conceives alcoholic drink to be making within the body. If favorable affinity exists, conscience finds nothing to condemn and will power is not called into action. If unfavorable affinity does not exist, the creating error in energy is absent. Conscience condemns and will power in defense forbids further indulgence. From the time of the first drink the effect of stimulants will be a part of the general intelligence and everybody will be reviewed from the intellectual standpoint of the viewer. Thus we account for the use and abuse of, and abstinence from alcoholic drink upon conscientious grounds of education through the sense of feeling.

This special alcoholic intelligence, woven with theory and what is believed to be facts, is modified by the forces of life and disease. The drunkard and drinker that is doomed to become a drunkard are largely conscientious in the use of stimulants, until there is a break in the continuity of cause and effect that produces drunkards, and through pain of declining health. Conscience has been awakened. Alcoholism makes its appearance; when it does there is a decided change in physical energy and early intellectual and moral conceptions. In fact, the whole "whisky philosophy" that began with the first drink is changed, punched out, and the drunkard acquires some wisdom from pain, a great teacher. The nerve lesion of alcoholism accounts for the physical state of the drunkard and his inability to reason and to will himself out of dissipation. Intoxication being a phase of insanity, the rule of change is verified by the monomanism, and that sometimes redeems drunkards from alcoholism. Isomeric change in nerve molecules by the action of alcohol upon albumin is the primary lesion of alcoholism and accounts for the changed, or wasted appearance of nerve cells and fibers as seen under the microscope. From the eternal fitness of things, could our foresight be as wise as the after recollections of a cured drunkard, regarding the use of stimulants, drunkenness would disappear from the face of the earth.

Morbid Physiology.—Vital energy is characterized by chemical affinities. When they are in harmony matter is vitalized, used and thrown off with smoothness of energy and the mind is spared from physical annoyance. Water, serum and tissue cannot be separated from heat, life and mind, and the natural elements of energy within the body are water dissolved, salts, gases, corpuscles, in suspension, albuminoids, heat, light and electricity. The ease of health is due to harmonious adjustment of these elements, while disturbance of them through the national circulation creates disease. The first evidence of disease is inability to rest. Reasoning by exclusion from this point we find where definable types of disease are associated with drinking propensities in one class they occur in others who do not drink stimulants. Cold, hunger, darkness, over-work, loss of sleep, as such, operating to change the units of energy, do not create affinity for stimulants however much they vary appetite in habitual drinkers. Individuals who do not get intoxicated but take stimulants as a medicine are not here relevant. The forces within and without that increase or diminish the units of energy may carry it to the extremes without creating affinity for stimulants except when energy is peculiarly modified by chemical affinities of a character that produce the drink impulse. The vital circulations are like an electric current. So many elements represent a given amount of power. When the reserved energy maintains the balance between supply and consumption there is smoothness of action, otherwise there is shock. This interrupted condition protracted must result in some definite form of disease, following from inability to rest. Naturally a remedy is sought, anything that will check disintegration gives comfort. Alcohol does this. It always is prompt and efficient and hence is taken. In this state the reaction from a quantity of alcohol that would make an individual with correct energy miserable is well borne. The greater the affinity, the deeper the delusion produced by stimulants and the more likelihood of protracted drunkenness.

Take away elements of nutrition, such as phosphate of lime, and as the victim goes into physical decline

*Read before the Mississippi Valley Medical Association, October, 1892.

he will try to maintain stability in drunkenness. Life is sweet, and when some people are, or think they are, dying faster than they are living, they seek rest from the death process, or exchange one delusion for another by unintentionally getting drunk. Thus the habit is formed which leads to alcoholism and through the pain that is incidental they sometimes learn how to get well. General observation and the curative effect of many agents confirm these views.

Agents that lessen the elimination of urea oppose alcoholic affinity, while in alcoholic disease some agents that increase urea, free the system of alcoholism.

Alcoholic craving comes from shock produced by a morbid chemical process of nutrition, tending to destroy coördination of the energies and producing through ever so slight an intelligence of the effect of stimulant drink an impulse that determines to drink. By supplying the material that prevents the drink impulse is to do what alcohol does in effect. Alcohol in response to the drink impulses recovers coordination in energy, while it destroys vitality by consuming oxygen that should be used for purifying tissue material. Food only stops craving in a drunkard while it is digesting in the stomach by the same principle that an injured child will not complain while you hold its mouth shut. The reason why women as a class drink less than men is due to their feminine nature. Hopeful and devotional without self-reliance, relying on others in her natural sphere her life is subdued. Though often delicate, nervous and emotional, her energy is smooth and she adapts easily to conditions of rest. In seeking her greater liberty by an effort to break the bondage of her feminine inheritance she assumes responsibilities beyond her true sphere. She grows coarser and stronger, is less loving and lovable because more self-reliant and masculine. In this change she comes to live intensely and easily acquires the condition of energy that is productive of drunkenness.

The chemical evidences of the correctness of these views are found by urinalysis. Nature always tends to throw off that which is obnoxious and once freed tends to remain well. A large number of cases that had been "gutter" drunkards for ten and some for thirty years, cured under my care more than a year ago, have remained sober ever since, and are active and healthy.

In any of the variety of cases the substance used for curative purposes do no harm if there is an excess of them in the body they represent, the excess is promptly eliminated by the eliminatory organs. While family history necessarily figures high in the treatment of these cases to correct morbid physiological conditions by the use of harmonizing and vitalizing bodily elements, direct and indirect. Sthenic and asthenic cases call for nearly opposite treatments. The desire for stimulants knocks out in a few days, but the system must be sustained or habituated to the corrected conditions by several weeks' faithful treatment or until the patient feels that the effects of dissipation are removed. In broken down cases following a debauch, medicines must be given to allay nervousness and sustain strength, that are not curative to prevent suffering, while spirituous drink is being made offensive to the system and the alcohol within the system is being distroyed or eliminated. After this has been accomplished, food, light, air, water, sleep, etc., and exercise are all the system will need or demand, and there will be an abhorrence of alcoholic stimulants. Our aim is to treat the drink habit for the very best results science of medicine will afford or upon the rational grounds of the true nature of alcoholic disease without nauseating the system into disgust of stimulants at the expense of vitality, but on the contrary destroy appetite without violence to the system and at the same time build up the physicial and mental strength of the drink habit. I have made hundreds of experiments treating cases upon their merits. Experience has demonstrated that alcoholic lesions can be made to rapidly disappear as a rule by uniform treatment, when special treatments are provided for three kinds of cases made up from sthenic, asthenic and special family history conditions. Organic disease due to intemperance in strong drink that is incurable is always checked in devolopment. Results that are curative are obtained through correction of morbid physiological conditions and are not attended by the violent reactions and other unsatisfactory results that are associated with narcotic treatments. The treatments of the liquor habit should be reclaimed to and held within the profession for the advancement of general good. It is exceedingly unfortunate that doctors as a rule ignore ill health from drunkenness (except to treat immediate results) out of consideration for routine work. In the true sense of the healing art this kind of practice is as honorable and worthy of pursuance as any other. In view of the needed medical aid to succor the fallen by destroying appetite for stimulants and freeing them from alcoholic disease, thereby placing them upon neutral grounds with a new and hopeful prospect of happiness, makes this humane department of practice very inviting to me.

Treatment of Typhoid Fever.*

By F. Shimonek, M. D., Milwaukee, Wis.

I ask the Society's indulgence in what little of value I have to say on this subject of practical interest to all physicians in active work. The scientific discussions and investigations at present, have perhaps somewhat overshadowed the everyday aspects of our calling, admitting at the same time the absolute necessity of such scientific researches for the rational treatment of disease; but we as practical men have more to do with the deductions thereof than with the details of those interesting and valuable experimentations. It is to us to whom the suffering public look for aid in their distress of body and mind. Therefore, one possessing any facts bearing on the treatment of any disease, need offer no apology for presenting them; furthermore, it is his duty to give his ideas and experience with such therapeutic measures with which he is mostly acquainted in the management of any disease.

The mass of literature on the treatment of typhoid fever is enormous, and it can be said without fear of contradiction, that not many recoveries were directly due to the remedies employed; for the sufficient reason that the etiological factor was absolutely unknown. The treatment may justly be compared to a rudderless ship sailing here and there until either stranded on some coral reef or by mere chance safely harbored, with greater chances, by all odds, of running into annihilation.

*Read before the Milwaukee Medical Society, 1892.

Thanks to the indefatigable generation of bacteriological investigators, our way is now supplied with guide-posts pointing to the myriads of vicious little enemies gnawing at our vitals and producing ten-fold more harm and destruction by generating the toxalbumins during their production, growth and decay. It has been well established that the bacillus typhosus is the cause of the disease. It was discovered by Eberth in the spleen, lymphatic glands and Peyer's patches of patients dead with typhoid fever, and in the urine and fæces, but not in the blood. It is supposed that it secretes the poisonous ptomaine typhotoxin, which is regarded dy Serotinin, as the cause of the general manifestations of the disease.

The recent attempts at producing typhoid in lower animals, by Fränkel, Simmond, Seitz and Sirrtinin, have been successful and a typical disease more or less resembling typhoid fever, in symptoms and pathological lesions, has been produced.

It is not necessary ndr desirable to enter here into any extensive dissertation for the purpose of proving that that bacillus is really the specific cause of typhoid fever, suffice it to say that because typhoid is characterized by certain definite intestinal lesions it seems no more than reasonable to suppose that those lesions are due to definite or specific etiological factors. The *materies morbi* is always found primarily in the intestinal canal, and subsequently penetrates the mucous membrane and subjacent tissues or lodges in the spleen, intestinal glands, some of which undergo destruction. Taking it for granted that the preceding is correct, it certainly appears logical that the proper treatment is that one whose object is the destruction of the primary and propagating cause of the general manifestations of the disease. The symptomatic and dietetic management aimed to alleviate the patient's suffering and to bridge him over the worst, and if his constitution and the will of God willed it he would withstand the inroads of that terrible toxæmia and would come out of the contest victorious, but often a permanent wreck.

We certainly have arrived, or are with great strides arriving where we can attack the *fons et origo mali* with increasing success. I do not desire to weary you with a view of the various methods at odd times in vogue, they were one by one cast aside for the simple reason of an erroneous idea of the pathogenesis.

Intelligent physicians adopted from the heap of ruins, the meeting of the indications as they presented themselves to their observations, as the guide for the rational treatment of typhoid fever. The treatments varied according to the different views entertained by the clinicians; if, as Leibermeister regarded the pyrexia as *the* thing to be mostly dreaded, he would necessarily resort to some one of the various antipyretics, and the one mostly in vogue was enormous doses of quinine, due chiefly to the earnest advocacy of Leibermeister. I have frequently heard it said when making disparaging remarks about that treatment, that I did not give it as Leibermeister advised, in 16½ or 22½ grain doses, therefore could not expect the same results. The mortality under it was from twenty-five to forty-five per cent, really higher than under simple symptomatic management, for the reason that, to a certain extent, it was supreme in one's mind, and other important matters were regarded as secondary.

The questions now to be answered are: Have we at present anything better than merely symptomatic handling? Has the mortality been reduced as a consequence of the discovery of the typhoid bacillus?

I think that those questions can be answered affirmatively. Those practitioners who have availed themselves of the results of modern bacteriological investigations and have heartily accepted them as the only true guides, have, I think, no cause for regret. I believe too, that the fact that we had not yet arrived at anything at all resembling a general consensus of opinion regarding its treatment is further evidence that many cases must be improperly treated, and that thus much of the high mortality is to be accounted for, although it is true that the most successful treatment, i. e., hydrotherapeutics, does not strike at once at the root of the disease, it is nevertheless true that it diminishes the evil consequences by abstracting excessive heat and thereby restoring the functional equilibrium of all secreting and excreting organs, enabling the removal of the products of bacterial life, resulting in improved circulation and nutrition, thus bringing about an improvement in the general condition of the patient.

Statistics from some of the largest hospitals which seem to be unimpeachable show what an immense reduction of mortality has been produced by cold baths in some form or another, yet the strictest adherence to the Brand method far exceeds them in value; nevertheless they are in private practice not applicable. We have also to contend with popular prejudice.

There is one thing, however, which detracts from the value of Brand's method, and that is, that in order to get the full benefit, all cases must be received for treatment before the fifth day of the disease and still better before the third. Now, I dare say that there are precious few who possess such diagnostic acumen as to be able to make an undoubted diagnosis at so early a period, all such cases must of necessity be statistically of doubtful value, notwithstanding all enthusiastic advocates of the treatment count them all for positive cases. However, cold water, used in some way or another, has a tendency to greatly lessen the suffering but at the present time we are not able to place an approximative value on its usefulness.

Some of the enthusiasts in Europe claim to have reduced the mortality to a fraction of one per cent. No such results have been attained on this side of the Atlantic, not because it has been improperly used, or by less experienced physicians, but because most of the cases come under treatment later in the course of the disease, into our hospitals, when there cannot be any doubt of the proper diagnosis. I do not wish to be understood as opposing the Brand treatment, but I do affirm that its value has been overrated.

I have quite frequently resorted to the pack or cold sponging, and mostly with happy consequences; sponging, particularly, can be entrusted to any intelligent person, without feeling that one placed a double-edged knife into the nurse's hands, on which account I have never felt courageous enough to order the cold plunge. For the best interests of the patient the presence of the physician is positively demanded during the use of the Brand method.

In speaking from the standpoint of a private physician this treatment cannot find acceptance. This paper is not for the purpose of championing private or peculiar views, or any one or a combination of remedies as infallible in the treatment of typhoid fever, but merely giving personal opinion and experience with intestinal antisepsis founded on rational deductions.

At brief periods during the last decade, intestinal antisepsis found advocates who but feebly supported their opinion because based only on imaginary *materies morbi.* The natural growth of the typhoid bacillus being primarily in the digestive tract the question is, "Do we possess any article which will destroy or inhibit their life *in loco* without at the same time producing any deleterious action on the constitution in general? Judging from the various favorable reports and from my very limited experience, I think that we possess in beta-naphthol such a remedy. I have found it work so well, that unless the stomach is very irritable, which is a contraindication to its use, I invariably, give it and my results guarantee the statement that it is an agent *par excellence* in the rational treatment of typhoid fever. It is very insoluble and having at the same time sustained and powerful antiseptic properties. Moreover, it is only toxic in very large doses, in fact, according, to Bouchard's investigations nearly one-half pound would be required to cause death in a healthy person of average weight, while about four grains daily is abundantly sufficient to keep the intestinal contents aseptic. Shoemaker says it is one of the most powerful antiseptics, possessing three times the strength of carbolic acid, or iodoform, or four times that of naphthalin or creosote. He further says: "In typhoid fever it mitigates the severity of the disease and reduces the rate of mortality. The stools are deodorized, tympanites lessened and the tongue moistened, delirium rarely makes its appearance." Dr. Peabody says, regading beta-naphthol and resorcin: "The reaction even though it might have been ever so plainly present when the patient began treatment, and it was so almost invariably—usually disappeared after the first few doses, and remained constantly absent while the drug was being given. It promptly reappeared if the drug was stopped during the pyretic period. The effects upon the temperature and duration of the disease seemed quite unmistakable, and about the same with either drug." He also speaks of unpleasant consequences of beta-naphthol which was the occurrence of blood, albumin and casts in the urine of a few patients, which, however, promptly disappeared when the drug was stopped. He does not mention the quantity given. I have never noticed similiar effects, after five grains every two hours, which I have found quite efficient.

It is not necessay to quote any more. I can conscientiously say that my experience with it amply confirms those results. When I commenced the use of it some three years ago, it modified the condition to such an extent that frequently I became doubtful respecting the correctness of my diagnosis, but I learned to depend upon it, that I always expect a speedy amelioration of all the general symptoms. When the diarrhœa is profuse it is best to add bismuth because it is a good antiseptic. While the temperature in most of the cases has been lowered, still when it persists high I use phenacetine in small, and as often repeated doses as is found necessary. Phenacetine given that way is not a depressant, for under its use the pulse improves in quality and becomes steady and full. I have never given more than five grains, and frequently half of that amount, repeated in an hour or two until the fever begins to go down. In this manner I am able to keep my patients quite comfortable, and believing, further, that their suffering is decidedly abridged.

It is stated by some one, that the typhoid bacillus exists only for the first two weeks of the disease, and that the subsequent course is due to infection by septic germs absorbed through the ulcerated glands; if this be true, that alone forms a decided indication for intestinal antisepsis, and it would seem nothing strange to abort it at any rate during this time.

Cold water, by rectal injection, has served Dr. J. Morton well in *adherent placenta;* it acts by reflex stimulation.

Dr. Henry T. Byford has been elected as "Professor of Gynæcology and Clinical Gynæology," and Dr. Henry P. Newman, as "Professor of Clinical Gynæcology and Lecturer on Gynæcology," at the College of Physicians and Surgeons.

A New Professorship in the Jefferson Medical College.—At a meeting of trustees held on Wednesday, Nov. 30, 1892, Dr. G. E. de Schweinitz, was on the unanimous recommendation of the faculty elected Clinical Professor of Ophthalmology in the Jefferson Medical College.

At the time of election, Dr. de Schweinitz was Professor of Ophthalmology in the Philadelphia Polyclinic, and Lecturer on Medical Ophthalmoscopy in the University of Pennsylvania.

Alvarenga Prize of the College of Physicians of Philadelphia.—The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Señor Alvarenga, and amounting to about $180, will be made on July 14, 1893, provided that an essay deemed by the committee of award to be worthy of the prize shall have been offered.

Essays intended for competition may be upon any subject in medicine, but cannot have been published, and must be received by the Secretary of the College on or before May 1, 1893.

Each essay must be sent without signature, but must be plainly marked with a motto and be accompanied by a sealed envelope having on its outside the motto of the paper and within it the name and address of the author.

It is a condition of competition that the successful essay or a copy of it shall remain in possession of the college; other essays will be returned upon application within three months after the award.

The Alvarenga Prize for 1892 has been awarded to Dr. R. H. L. Bibb, of Saltillo, Mexico, for his essay entitled, "Observation on the Nature of Leprosy."

Charles W. Dulles, *Secretary.*

Simple Water Test.—Into a ground glass stoppered, perfectly clean, bottle put five ounces of the water to be tested. To the water add ten grains of pure, granulated, white sugar. Cork tight and set in a window exposed freely to light, but not to direct rays of the sun. Do not disturb the bottle, and keep the temperature as near 70° F. as possible. If the water contains organic matter, within forty-eight hours an abundance of whitish specks will be seen floating about, and the more organic matter the more specks. In a week or ten days, if the water is very bad, the odor of rancid butter will be noticed on removing the stopper. The little specks will settle to the bottom, where they appear as white flocculent masses. Such water should not be used for potable purposes.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Phenacetine.

The season of acute inflammatory disorders is with us, and it is proper to ask: What are our means of defense? What progress have we made in the treatment of these conditions? What new remedies are available, and do they act more promptly and effectively than the drugs of the fathers? A review of the clinical notes of practitioners, as made during the past year, would seem to show that the chief reliance in such states, as pneumonia for instance, must be placed upon remedies that quiet pain and reduce temperature. Dr. William Bailey, in a recent article on "Progress in Practical Medicine" (Ky. S. and Med. Society), says of the newer antipyretics in fevers: "Of this group I have been inclined to favor Phenacetine because it gave the best results with the minimum of danger by heart depression."

Dr. R. W. Wilcox (as reported in the *Ec. Med. Jour.*, August, 1892), gave phenacetine "in the high fever of pneumonia, and avoid opium." In the *Times and Register* of April 23d, 1892, Dr. Waugh, in an article on pneumonia writes: "Phenacetine is the only antipyretic to be used." Dr. Bailey (Loq. Cit.) found that phenacetine gave as good results in typhoid fever as in pneumonia. He says: "I gave phenacetine more frequently than all of the others together for the reduction of fever, and I give it without hesitation under all circumstances." He also found it of great value in pertussis. Dr. Laughlin fully confirms Dr. Bailey's experience of the value of phenacetine in pertussis.

In acute rheumatism Dr. Stampke has found, with other observers, that phenacetine in fifteen grain doses, three times a day "gives better results than antipyrine, antifebrine, quinine or the salicylates." In gonorrhœal rheumatism also, usually so obstinate, Rifat has most successfully employed phenacetine.

Dr. Hunter Robb advises (Maryland *Medical Journal*, May 14,) the use of phenacetine "as a substitute for morphine in gynæcological practice," and it seems to be largely replacing the opiates in these States. Of the value of phenacetine in *la grippe* in its multiform manifestations, all practitioners are fully aware. In its combination with salophen it will probably prove exceptionally effective in cases of influenza in patients having a rheumatic diathesis, while in uncomplicated cases its power is widely known.

ABSTRACTS.

Surgery.

GUNSHOT WOUND OF STOMACH.—A singular case was reported at the meeting of the Georgia State Medical Association in April. The patient, a negro, had received a pistol shot said to be in the stomach. After careful examination the doctor found that in the fight, which had occurred two hours previously, his patient had received a wound directly over the stomach. A casual examination with the eye alone was all that was necessary to show that the ball had penetrated the cavity of that organ. A more thorough examination was made with the probe, and it was found that the ball had entered at a point about two inches below and to the left of the nipple, at the tip of the ensiform cartilage of the sternum. The probe passed readily into the cavity of the stomach, and the doctor supposing that the ball had passed through and lodged in some other portion of the body, did not pursue the examination further. At a third visit which was about forty-eight hours after the boy had received the shot, he ascertained that there had been two or more free evacuations from the bowels, and to his great surprise, the ball had passed with one of these evacuations. The wound healed by first intention, and just one week from the date of the injury the boy returned to his work.—*Southern Medical Record.*

TREATMENT OF COMPOUND FRACTURE.—A writer in the *Boston Medical and Surgical Journal* says that the treatment of compound fractures, during the past few years, has undergone radical changes and marked improvement, which has been brought about by two causes: (1) Thorough exploration and cleansing of the wound and antisepsis. (2) By the recognition of the importance of the physiological principle of complete rest to a fractured bone. The results from older methods in Guy's Hospital in the twenty years from 1841 to 1861, was a mortality of twenty-eight per cent; in the New York Hospital during a similar period there was a mortality of forty-eight per cent; in the Obuchow Hospital Report of St. Petersburg there was a mortality of sixty-eight per cent. Under modern methods Dennis reports 681 cases of compound fracture with one death from sepsis, giving a death rate of one-seventh of one per cent. The important points to be observed are: (1) That every compound fracture of the thigh, leg, arm or forearm, should be rendered scruplously surgically clean and should be absolutely immobilized. (2) That this immobilixation is conveniently obtained by the light, circular plaster of Paris washed bandage. (3) That a plaster of Paris bandage should be allowed to remain on a limb over a fortnight in the first month of treatment of a compound fracture, as backward bowing and laterel displacement can be avoided by this precaution. (4) That while pus, slough, necrosis or deformity may exceptionally occur, yet the rule is, union by first intention, and the early restoration of limbs to usefulness.—*N. W. Lancet.*

THE USE OF NITRATE OF SILVER IN URETHRAL INFLAMMATIONS.—Dr. R. Guitéras (*Journal of Cutaneous and Venereal Diseases*) says:

Nitrate of silver is not dangerous in acute urethral inflammations as is generally supposed.

By beginning with small doses and increasing daily a tolerance can be established (the same as in chronic cases).

Although a solution of the strength of fifteen or twenty grains to the ounce can be reached in this way, it is not wise to go above eight or ten grains; and then if the result is not favorable to continue with some other means.

In this, as in bichloride irrigations, and all other methods which try to cure this trouble quickly, a dry, congested and slightly irritated condition is liable to follow, which should be treated for some days by mild astringents, these to be left off gradually.

When the discharge becomes very slight, it is better at times to decrease the strength of the arg. nit. than to increase it.

In cases of gonorrhœal cystitis, which are usually acute, good results are obtained by instillations of this drug.

In cases of chronic deep urethral inflammations, especially those of a granular nature, deep urethral injections are the remedy *par excellence.*

Nitrate of silver as an abortive should not be used, as in doing this peri-urethral inflammations may be set up, which might cause considerable trouble.—*Med. and Surg. Reporter.*

WIRING THE PATELLA.—In an article on fractures of the patella (*Phil. Polyclinic.*), Dr. John B. Deaver states that the points aimed at in writing are first, to free the interval between the fragments of bone of the fringes of the torn capsule and synovial membrane; secondly, to clear the joint of blood clot; and, thirdly, to obtain absolute apposition of the fragments. The objection to wiring fractures of the patella when union has failed to take place, where refracture has occurred, or when the union which has been fibrous has lengthened to such an extent as to seriously impair the usefulness of the limb, are certainly not as strong as against the wiring of recent fractures. The contraindications to wiring are advanced age, the presence of kidney lesion, diabetes, markedly impaired general health, addiction of the patient to alcoholism, when delirium tremens would be likely to follow the most trivial operative procedure. Further, wiring is contraindicated when the soft parts have sustained severe injury, making sloughing liable, as well as when the fracture is of the stellate variety, whether simple or compound. In certain compound fractures of the patella the treatment does not differ from that of similar fractures of other bones. In recent fracture of the patella, where the line of fracture is so irregular that it prevents close approximation, a removal of a section of bone will be necessary. In ununited fractures, in fracture occurring at the site of previous fracture, and in those cases where the union has been fibrous, a section of bone should be removed. Dressing with plaster of Paris where the fragments have been wired, I regard as an essential part of the treatment, believing that by its use the field of operation is much better protected.—*Kan. City Med. Index.*

Medicine.

ERYSIPELAS.—The mechanical treatment of erysipelas by means of strips of adhesive plaster is recommended afresh, by Wolffler (of Graz). This is applicable not only to the extremities, but also to the trunk, to the face and hairy scalp (after shaving), and in its application makes a wall, obstructing the advance of the erysipelatous infection. Great care must be taken that the strips are so adjusted as to make a complete ring, and that the last applied do not relax the first put into position. To avoid relapses they must not be removed for at least four or five days after subsidence of fever and disappearance of the flush.

The statistics given by Wolffler seem very favorable, and the results are especially noticeable in the treatment of the facial cases. The cases of erysipelas in the lower extremities seemed to resist this method most stubbornly, which is also true of their resistance to the operative treatment proposed by Kraske and Riedel.

Should the treatment by plaster strips fail in these cases, we recommend the crisafication method.

Kroll (of Strassburg) adopts the same principle, but secures the end by the elastic compression of broad bands of rubber.

Gottstein (of Berlin) recommends that a one per cent sublimate ointment, using lanolin for the base, be applied in thick layers twice daily, over all the erysipelatous and neighboring sound tissue. Over this a cotton dressing is applied.

Winckler (Bremen) advocates the treatment with oil of turpentine as suggested by Lucke. Several times a day (four or five times in very severe cases), the affected parts were well rubbed with oil of turpentine, using a brush, or wad of cotton.

Before the first application, thorough cleaning of the skin with ether, or absolute alcohol is advised. To avoid any dislodgment and dispersing of the germs, the friction should be made in the direction from the edge of the erysipelatous portion ot skin toward the center. Over the diseased portion a cotton dressing is applied, and the application is renewed in from two, three or four hours, according to the severity of the case.

The suspected point of entrance of the infection must be disinfected as thoroughly as possible, small ulcers cleaned of adhering crusts and covered with sublimate lanolin (one per cent). Inasmuch as the use of turpentine is contraindicated in cases complicated by albuminuria, the urine must always be examined before this treatment is entered upon.

Ichthyol, applied by von Nussbaum and Fersher in the Munich hospital, has been warmly recommended from every side; it is claimed to be a direct specific against erysipelas, which lessens the intensity of the disease and shortens its duration very materially.

It is usually applied as a salve (Ichthyol, Vaseline aa; or Ichthyol, Aq. dest., Lanolin aa), two or three times daily on the erysipelatous skin, which has been thoroughly scrubbed with soap and water. Over this is laid a salicylated dressing and cotton. It is very important that the application be made not only on the actively inflamed skin, but also well out on the sound portion adjoining, and to continue it a day or two after the fall of temperature. * *

Ullrich (*Hosp. Tidende*) prescribes as follows:

℞ Ammon Sulpho-ichthyol.....ʒss.
Ether Sulph.....ʒss.
Collod Elast.....ʒi
Mix.

—*Med. and Surg. Reporter.*

STERILITY IN THE MALE.—Dr. L. Seeligmann states that matrimonial sterility caused by the husband may be due to the following causes:

1. Impotentia coëundi.
2. Aspermatism.
3. Azoospermia.

Of these three causes of male impotency, the comparatively rare condition of impotentia coëundi, and the almost equally rare condition of aspermatism, we may pass by and proceed to a consideration of azoospermia as the most frequent cause of sterility, or rather impotency, in the male.

Azoospermia, or a change in the ejaculatory fluid in which both quantitatively and qualitatively the semen is apparently normal, but in which the most important element, the spermatozoa are absent, can be caused by the following:

1. Stoppage of the vasa deferentia in consequence of inflammation or traumatism.
2. Nutritive disturbances of both testicles:

a. Occurring after funiculitis, epididymitis, and duplex orchitis.

b. From constitutional diseases; syphilis, tuberculosis, chronic alcoholism, diabetes mellitus, etc.

c. From varicocele, hydrocele, kryptorchimus.

3. Atrophy of the testicles:

a. After sexual excesses.

b. After long indulgence in onanism.

c. After injury to certain parts of the brain, especially of the cerebellum.—*Weekly Med. Review.—Med. and Surg. Reporter.*

RESPONSIBILITY OF PHYSICIANS IN THE USE OF CHLOROFORM.—Dr Passet formulates the rules for administration which should be carefully observed: 1. Before each narcosis there should be made a careful examination of the patient, and especially of the organs of circulation and respiration. 2. Chloroform should be only administered when well mixed with air. 3. The anæsthetic should be stopped with the advent of tolerance or at the disturbance of respiration or circulation. 4. The circulation and respiration should be continually watched, and at any disturbance of these functions the appropriate remedies should be used with discretion and energy; when death is imminent the artificial respiration and other methods of recuscitation should not be stopped too soon. 5. Both chloroform and ether narcosis are avoided during stomach digestion, and tight clothing and false teeth are removed before it is begun. 6. No anæsthetic should be used which one knows, or which (after examination) one can know, to be impure. Whatever happens when all these rules have been carefully followed, should not be laid to the physician, for *ultra posse nemo tenetur.*—*Munchener medicinische Wochenschrift.—Progress.*

OBESITY TREATMENT.—Prof. Dujardin-Beaumetz treats obesity in the following manner:

Every morning the body is sponged with tepid water to which some cologne water has been added, after which energetic dry friction and massage of the body and of the limbs are practiced. A wineglassful of some laxative water (rubinat, carabana, villa cabras, etc.) is taken every morning, and after each meal, a tablespoon of a 6:100 solution of potassium iodide in distilled water. The following regimen is to be strictly followed:

Breakfast should be taken at about 8 o'clock, and should consist of 20 grammes (5 drs.) of well-baked and crisp bread and 1 chocolate tablet. The *second meal,* at about noon-time, is to be constituted of 100 grammes (3¼ oz.) of meat or 2 eggs, 100 grammes of green vegetables or salad, 15 grammes (½ oz.) of cheese, 50 grammes (1⅝ oz.) of bread, and a moderate quantity of fruit. A glass and a half of white wine is also to be taken, diluted with Vichy water. The *third meal,* at about 7 o'clock in the evening, should consist of 100 grammes (3¼ oz.) of meat, 100 grammes of green vegetables, 15 grammes (½ oz.) of salad or cheese, 50 grammes (1⅝ oz.) of bread, fruit in moderate quantity, and drink as at noon; soup is to be avoided.

No drink should be taken between meals, and the use of coffee, tea, brandy and liquors, is to be abstained from. Finally, exercise progressively increased and with increasing zeal completes the treatment.—*Merck's Bulletin.*

TREATMENT OF ASTHMATIC ATTACKS.—Dr. Dieulafoy says: When an attack of asthma begins, the nasal fossæ should *immediately* be painted as far upward in their interior as possible with a pencil soaked in a solution of cocaine hydrochlorate (1 part in weight to 20 of water). Or, better still, spray the nose or the pharynx with this solution for four or five minutes.

This treatment very often puts an end to the attack. If it fails, the patient should deeply inhale six to twelve drops of pyridine poured on a handkerchief.

When the asthmatic attack reaches its climax, an injection of a solution of morphine hydrochlorate is made (1 part in weight to 100 of distilled water. At first, eight minims are injected. If the attack does not abate at the end of fifteen minutes, the dose is repeated.

Apart from the attacks, three medicaments are indicated for combating the diathesis: potassium iodide, arsenic, belladonna.

When the asthma is accompanied by emphysema, very favorable results are obtained by *compressed air baths.—Merck's Bulletin.*

THE TREATMENT OF DELIRIUM TREMENS.—The author asked first, What was delirium tremens? Was it a morbid state, which was the issue of neurasthenia, or was it an effect of alcoholic poisoning? He believed it to be the latter, and that the disease arose from the cumulative specific action of the poison of the cerebral tissues through the alcoholization of the blood. Acting on this theory, he had aimed at eliminating the poison from the brain and nervous system, leaving the healing power of nature to do the rest. This was the view taken in 1854 by Dr. Alexander Peddie, who administered antimony. Dr. Kerr, however, has found liquor ammonii acetatis to satisfactorily fulfill the conditions most favorable to cure. The main point was to avoid the use of alcohol and opiates, chloral and all narcotics. The best hope of cure lay in natural exhaustion inducing sound, refreshing sleep.

The differing results of narcotic and nonnarcotic treatment were exemplified in the case of a publican, who, in his second attack, was treated with opium and bromides, and in his third attack only with liquor ammonii acetatis. In the former seizure the patient, aged 42, even after sleep was so heavy, unrefreshed and then violent, that it took four men to hold him.

To save his life he had to be put into a padded room in the work-house, where he raved till exhausted and procured sleep, his only beverage there being coffee. In the latter seizure, two years afterward, he was treated at home, the only medicine being liquor ammonii acetatis, at first in drachm doses every hour; milk, beef-juice, broth and coffee were given frequently. In about seventy hours he had a sound sleep for four hours, followed in four hours more by a spell of twenty hours' sleep. The latter attack was complicated with an epileptic fit. The recovery was quicker than from the previous attack. These were both typical examples of the graver form of delirium tremens. By a reliance on so safe a sudorificas liquor ammonii acetatis and suitable nourishment, we best fulfill the conditions of cure, as we hereby give the *vis medicatrix nature* a fair field and no favor.—*Thera. Gazette.*

Condition of the Blood in Gastric Affections.—A considerable amount of uncertainty has hitherto existed in reference to the condition of the blood in connection with gastric affections, especially in ulcer and malignant disease of the stomach, and authors differ greatly in their statements on the subject. Orterspey has made some careful experiments in order to attempt to clear up these doubts, and the following are the results he has obtained: In nine cases of ulcer of the stomach the results were very uniform—diminution in the amount of hæmoglobin and in the number of red blood-corpuscles, these changes being particularly marked in those patients who had had hæmatemesis. These results of course correspond with the anæmic state so constantly met with in connection with this disease, and all previous investigators have found the same condition. Out of twelve cases of cancer of the stomach, in one the blood was perfectly normal, in eight the number of red discs was diminished, in eleven there was a diminution in the amount of hæmoglobin present, in five there was an increase in the number of leucocytes, while in two, although the hæmoglobin was diminished, the red corpuscles were about normal in number. All these changes are neither characteristic of the cancerous cachexia generally nor of cancer of the stomach in particular, as they also occur to a similar degree in the course of many other affections. There is therefore no diagnostic difference in the blood to be noted in the two diseases, ulcer and carcinoma of the stomach. There is, perhaps, more value in the examination of the blood in doubtful cases, when there is uncertainty as to the case being one of malignant disease or chronic catarrh or a neurosis of the stomach, as the last two sometimes lead in extreme cases to the absence of hydrochloric acid in the gastric juice.—*Lancet.*

Gonorrhœa and Heart Disease.—His (*Berlin klin. Woch.*, October 3, 1892,) records two cases of cardiac disease, the result of gonorrhœa. In neither case has there been any previous history of rheumatism, or any ground for considering the cardiac affection rheumatic. The first was one in which there was no joint affection at any period of its course. Septic thrombosis of the prostatic veins and pubic plexus resulted from a gonorrhœa, and the next manifestation of the septic process was affection of the aortic valves. This was at first latent, but after intense emotion and a severe chill, it assumed the charaters of an ulcerative endocarditis. Later the condition became pyæmic, with septic emboli in internal organs, multiple hæmorrhages in these and under serous surfaces and interstitial inflammation of the heart muscle which resulted in cardiac failure and death. The second case differed from the first in having joint affection, which the author considered of septic origin, and in not having thrombosis of the prostratic veins. The latter, however, may have been overlooked at the necropsy.—*British Med. Journal.*

Clinical Forms of Pernicious Cholera, during the Epidemic of 1892 in Paris.—Gilliard classifies the cases, based on the rapidity of their evolution, in three classes.

1. The malignant (foudroyant) form, that which kills in twenty-four hours at the furthest, but which may be prolonged or even cured by the intravenous injection of Hayem's serum.

2. The galloping form, which kills in five days at most, but which also may be prolonged, and sometimes even cured by transfusion and sometimes without. This galloping form should be considered, according to Galliard, as the type of the epidemic of 1892. This differs from the first variety principally by the fact that it is more amenable to treatment, on account of leaving more time to act.

3. The slow form, three varieties:

(*a*) Gastro-intestinal, the one curable form of this class.

(*b*) Ataxo-adynamic, always mortal.

(*c*) Marantic, also mortal.

This slow form may last three weeks. The termination may be either by a state of peripheric algidity (with or without central hypothermia) or by congestion of the nervous centers, or from a complication, such as pneumonia.

The exanthem of cholera popular (erythema) comes on on an average about the tenth day. It has no prognostic signification.

Galliard attributes three cures to transfusion, in the malignant form; and estimates that thirty of his patients have been saved by this means. None of them had more than two transfusions, whilst in the fatal cases, the injections often exceeded two, and in one instance six were given.

The 397 cases observed offered the following clinical particulars:

1. Not a single case of cholera sicca.

2. Premonitory diarrhœa often wanting in rapid cases.

3. The greater number of patients being in the collapsed stage it was often impossible to recognize the succession of the classical periods.

4. In the collapse, beyond the classical symptoms, there was noted painful contractions of the scrotum, a symptom which seems to have been passed over unnoticed, by authors generally. Very low rectal temperature, also observed at this time.

5. The terminal asphyxic phenomena existed in a large number of cases.

6. Cardiac weakness appeared to be constant.

7. Nervous phenomena frequent.

8. Congestive symptoms were developed several times, generally in the brain and membranes; the lungs, generally escaping the complication.

9. Reaction did not conform to the classical descriptions, *i. e.*, coming on spontaneously, but was the result of violent therapeutical pertubation by

intravenous injections, but then it was complete; revival, restoration of the central functions, return of speech, urination, pulse, and temperature.

10. The typhoid reaction of authors was not observed.—*La Medicine Moderne.—Times and Register.*

FEEDING IN FEVERS.—Milk seems to be generally regarded as a fluid, and a very harmless looking fluid it certainly is when it is put into the stomach; but if it is to be digested and assimilated at all, it is very soon transformed into a bulky solid after it reaches the stomach. There are many patients to whom milk in any form is repugnant, and to some of these it is exceedingly difficult of digestion. It has been my practice for many years, in all kinds of illness, but especially in the presence of fever, to pay regard to the appetite and desire of the patient. If a patient is really hungry solid food of a properly selected kind and in judicious quantity will rarely disagree with him. With hospital patients it is not always easy to ascertain whether they are really hungry. Many will profess hunger without being hungry because they suppose that they will recover more quickly if they eat freely. To them, of course, other solid food than milk should not be given, but if they are genuinely hungry I believe it is safe to presume that the stomach is prepared again to resume its function, that gastric juice is again secreted, and that properly selected albuminous food in judicious quantity will be digested if you give it.

We are accustomed, I think, to have too great a dread of doing harm at the site of lesion in the ileum in typhoid fever by giving solid food. If I am correct in my opinion as to the inference to be drawn from hunger in a fever patient, there is even less likelihood of causing damage to an ulcerated ileum by giving finely divided egg, or beef or chop to such a patient than by giving him milk; and my experience seems to justify the inference. It has been my practice for years to allow albuminous foods of these descriptions to such patients, even before the fever leaves them, under these conditions. I have at present under treatment several patients with typhoid fever whose temperature reaches 101°, 102°, and 103° F., daily, who are hungry, and who are receiving such solid food once a day. So far as I am aware I do not have a larger percentage of relapses or hæmorrhages, or other serious complications, or accidents in my practice than I did before I adopted this plan, or than my colleagues do who have not yet adopted it.

Even tea and coffee and beer are not allowed by by many doctors; in my hands they have been very useful when given to those who have been accustomed to them in health and desire them in fevers. Well-cooked oatmeal is another very nutritious food that I allow under the same conditions as meat.

When the appetite fails, in consequence of the presence of fever, meat becomes more repugnant than any other food as a rule. Then it would be most injudicious to force it upon a patient; but the returning appetite, the awakening desire for meat, I believe to be nearly always an indication that the stomach is prepared to take care of it. That much is gained by maintaining the nutrition of fever patients needs not to be mentioned to the members of this Society. Of course, the necessity of giving an abundance of water is not to be lost sight of.

What I have said of feeding typhoid fever patients is equally true in other forms of fever. It is, in my judgment, a mistake to withhold solid food merely because a patient has fever, and it is incorrect to regard milk as a fluid food, as our knowledge of the physiology of digestion teaches us. Our knowledge of the form in which milk often appears in the fæces emphasizes this latter fact. Milk will always remain the most serviceable general food in disease, and especially in fever, largely because it is swallowed with much less effort than attends the taking of other foods; because it is the cheapest of the foods; because it requires little or no preparation, and because it is so commonly well borne. But where it fails to nourish the patient, where it is not well borne, where it cannot be taken, for any reason, it is well to remember that efficient adjuncts and substitutes are within reach.—Dr. GEO. L. PEABODY, *N. Y. Med. Record.*

Therapeutics.

A SUGGESTED ELECTRICAL TREATMENT FOR CHOLERA.—Dr. L. V. Clevenger writes to the *Times and Register* as follows: Some means of acidulating the ilium contents would undoubtedly stop the ravages of cholera; upon this point bacteriologists are agreed, but how to do it is the question. Laparotomy is a severe undertaking, and flushing the colon with acidulated fluids would not insure the entrance of the fluid beyond the ileo-cæcal valve, which would resist its passage. Probably elevating the hips and filling the colon with acid oil, (tannic, acetic), etc., might admit of the small intestines being reached in time.

An electrical expedient occurred to me as theoretically warranted: The serum of blisters caused by the application of the positive galvanic pole is acid in reaction, the negative electrode causing alkalinity. I would suggest, therefore, experiments with animals to determine if sufficient current strength cannot be passed abdominally from a positive electrode to acidulate the intestinal contents for the time being. Either a large diffused electrode similar to the one used by gynæcologists may suffice, or the small testing electrode used in electro-diagnosis which concentrates the current. Let the physiological laboratories investigate and report.

THE EFFECTS OF ACIDS ON THE FUNCTIONS OF THE STOMACH.—1. Acids throw down a considerable precipitate of mucus.

2. They increase the cellular elements of the gastric contents.

3. Their introduction is followed by butyric acid reaction, most marked after hydrochloric acid.

4. Larger quantities of the acids result in a considerable effusion of bile into the stomach.

5. They stimulate the secretion of pepsin, but have no influence upon the secretion of hydrochloric acid.

6. Their long continued administration is followed by marked diminution of the secretion of hydrochloric acid.

7. Even in large quantities hydrochloric acid produces no gastric disturbances. On the contrary, a continued administration of the acid is attended with a feeling of well being.

8. The difference in the effect between acids and the alkaline salt on the gastric functions consists in the fact that the alkaline salts dissolve the mucus and decrease the secretion of pepsin, while the acids pre-

cipitate the mucus and increase the secretion of pepsin.

The disappearance of the alkaline salts from the stomach is followed by a decided increase of the hydrochloric acid secretion. This does not occur, or only to a slight degree, in the case of acids. Both the acids and salts, in large quantities in continued use, have the same effect in lowering the activity, and finally in destroying the function of the glands secreting hydrochloric acid.—*Jaworski, in Centralblatt fur Klin. Med.—Med. and Surg. Reporter.*

Calcium Sulphide in Tonsilitis.—F. P. Norbury has been very pleased with the effects of small doses of calcium sulphide in acute parenchymatous inflammation of the tonsils. These cases, especially if the subject be strumous, very generally tend to rapid suppuration. He has found that small doses (⅛ to ½ grain) of the sulphide, frequently repeated, are most valuable, both in preventing this suppuration and in hastening convalescence when the mischief is already advanced. Febrile symptoms and pain are greatly modified under its influence. In abscess of the mouth and throat Norbury prefers to apply a solution of hydrogen peroxide to which has been added a little oil of cassia, which he finds a thorough and most efficient antiseptic.—*The British Medical Journal.*

Phosphorus as an Antipyretic in Fevers in General.—Dr. C. Coleman Benson says: "My specific for all temperatures from 101° to 107° F., and dependent symptoms, is phosphorus, which should be given in temperatures from 99° to 101°, in doses of 1-150 of a grain every half hour for six doses, and then every two hours during the day, till reduction of temperature to normal. If the temperature varies from 105.5° to 107°, then give 1-100 of a grain every half hour for four doses, and then every two hours during the day till reduction in temperature to normal, never, however, exceeding in the twenty-four hours one-third grain, and even less if epigastric pain be produced by it. When the normal has been attained and remained so for twenty-four hours, then give 1-100 of a grain, with food thrice only in a day."

While I admit that phosphorus is a very excellent nerve tonic and stimulant, acting on the circulation through the nervous system, causing the pulse to be fuller and more frequent, distending the capillaries until free perspiration follows, and from its primary action increasing the heat of the surface of the body slightly, its secondary effect lowers temperature. It accelerates cell-growth in the body. It acts as a diuretic. The urates and urea are greatly increased in the urine; yet I do not think it should be considered a specific for fevers. It may act well as an auxiliary in the management of some cases, aud doubtless it does; but I think that antiseptics should form the basis of treatment in all cases which have sepsis as the exciting cause. While it may not play an important part in causing the fever under consideration, it does serve as the *materies morbi* in many cases of sickness attended with high temperature.

We should not allow ourselves to be led astray by hobbies and specifics, so-called, but should try to meet the indications in each individual case. It is well known that pyrexia results from various causes; therefore, we should select our remedies with the view of removing the cause as well as relieving the symptoms. —*The Atlanta Medical and Surgical Journal.*

The Treatment of Exophthalmic Goiter—Believing that in Basedow's disease the first indication is to combat the cardio-vascular erethism, Dieulafoy (abstract in the *Recueil d' Ophthalmologie*, August, 1892, p. 504) combines ipecac with digitalis and opium in pills composed as follows:

Powdered ipecac,.....gm. .035
Powdered digitalis leaves,....gm. .02
Extract of opium.....gm. .0025

Make one pill. From four to six to be taken every twenty-four hours.

Dieulafoy has treated several patients attacked with exophthalmic goiter in this manner, and has produced a considerable improvement in the symptoms. The effect of this medication is shown by an attenuation of the symptoms of the disease, very appreciable at the end of several days, and so noticeable after several months as to be equivalent to a recovery.—*Therapeutic Gazette.*

Methylene-Blue Inefficient in Malaria.—The reports of scientific investigators—particularly of Mya in the *British Medical Journal*, and of Thayer in the Johns Hopkins Hospital *Bulletin*—conclusively show that methylene-blue possesses no advantages over quinine in this disease, being rather inferior to this long proved remedy in positiveness and permanency of results. Its further use is not warranted by the showing of the severe tests made.—*Med. World.*

Bromoform.—*Physiological Action.*—Bromoform, in its physiological action, is similar to chloroform. When applied to the skin it is first cooling, then irritant, rubefacient and vesicant. Internally it is heating and burning, exerting a sedative, carminative and anti-spasmodic action. When inhaled it is anæsthetic, rather irritating to the mucous membrane, and not as desirable as chloroform. Its primary action is that of a diffusible stimulant, and if pushed, it soon depresses the nervous system and heart. It is eliminated from the system by the respiratory mucous membrane and kidneys, and is productive of irritation in those organs if large doses are administered. Its effect upon the nervous system is antispasmodic, for which purpose it is applied therapeutically. The small percentage of bromine in the combination adds to its antispasmodic virtues. Bromoform is also antiseptic.

Toxic Action.—When a toxic dose of a pure or impure preparation of bromoform is taken, there is a temporary stimulation and exaltation of feeling which is rapidly replaced by unconsciousness so deep that the patient cannot be roused; respiration is very shallow; pulse is very weak; pupils are contracted to mere points; there is general muscular relaxation; no convulsions; no cyanosis; cold skin, and odor of bromoform on the breath.

In such cases, artificial respiration may be necessary; galvanism. Apply heat to the body and cold to the head; rub the extremities from the periphery toward the body; stimulate freely with hot, diffusible stimulants or hypodermatics of strychnine, or, in some cases, morphine and atropine. When toxic action occurs in anæsthesia, treat as in chloroform narcosis.

Therapeutical Action.—Up to the present time bromoform has been used almost exclusively in the treatment of whooping cough, and most encouraging reports are recorded in favor of its universal

adoption, as *the* remedy for this disease. It has been administered in doses of one to five drops for children, three or four times daily, given in a teaspoonful of water—care being taken to see that the bromoform does not remain on the spoon, as it will not mix with water. Always begin with the minimum dose and increase it as necessary. It is the general experience of those who have used it, that whooping cough can be shortened in its course to three or four weeks. On the second or third day it is noticeable that the number of daily paroxysms has decreased; their severity and duration have been lessened; expectoration is favored; vomiting is lessened or entirely disappears.

Bromoform is a very uncertain remedy for patients to drop, as they are liable to get too much or too little. In my practice the following combination has been found preferable to the pure drug, and also insures greater accuracy of dose:

℞ Bromoform.....m xvj
Alcohol.....f3 ij
Misce tunc adde
Glycerin.....f3 xij
Tr. cardamomi comp.....ad.....f3 ij
Misce. Put in colored bottle. Shake label.
Sig.—One teaspoonful every four hours.

Six cases of typical whooping cough were treated by this method recently, in my own private practice, with an average duration of twenty-five days. The bromoform was given for about three weeks, as indicated, and followed for one week with malto-yerbine, thrice daily. No complications or sequela occurred in these cases.

Lowenthal gives a report of 100 cases of whooping cough (*Berlin klin. Wochensch*, No. 23, 1890) treated with bromoform, two to five drops, three times daily, in water, with the very best results, and claims that in bromoform he has found "almost a specific action."

A number of cases are reviewed in the *New York Medical Journal* (Vol. LII., 1890, p. 157) in which the author reports very encouraging results from the use of bromoform, claiming to cut short the duration and severity of whooping cough.

But the application of bromoform does not confine itself to the treatment of whooping cough alone. Small doses of the above combination may be used every half hour or hour, for one, two or three doses, to check stomachic pains and colic; also to relieve severe cough accompanying laryngitis, pharyngitis and bronchitis. If to the above combination you add one grain of antimonii et potassæ tartras, or one-half drachm of wine of antimony, you have an expectorant for a dry, tickling, hacking cough in an incipent cold.

Bromoform will never replace chloroform as an anæsthetic, for it is more dangerous and irritating in its effects and results.

What can we say about the objections raised by those who claim that the drug is dangerous and poisonous?

A number of cases of bromoform poisoning have been reported in our journals during the past two years, and from a general study of them it would appear that, (1) an impure preparation had been used; (2) too much liberty had been exercised in giving irregular doses by inexperienced persons; (3) too large doses had been given by those who were entirely ignorant of the physiological and toxicological action of the drug. Untoward symptoms will never result if a pure preparation is used with a *moderate* amount of conservatism, and the clinical experience of many who have used bromoform confirms this.

Conclusions.—No preparation of bromoform should be used unless it is absolutely clear and colorless; unless it is obtained from competent pharmacists; unless it is kept in nonactinic bottles in a cool place.

Bromoform should be given in combination rather than in its purity, to insure uniformity of dose and to avoid mistakes by patients dropping it from a bottle.

Bromoform finds its most extended application in the treatment of whooping cough, in which disease it exerts almost a specific action, greatly diminishing severity of symptoms and shortening its course.

Bromoform may be applied to the treatment of nearly every condition where chloroform is indicated, but will probably never replace the latter as an anæsthetic.

Bromoform must be used with caution; must not be placed indiscriminately in the hands of the laity; must be administered with certain restrictions, already indicated; and untoward symptoms will never result.

A Voice from the Arctic.—Dr. F. A. Cook, who was with Lieutenant Peary on his famous North Greenland Expedition, and which resulted in the closest approach to the pole yet attained, writes the following letter to the Antikamnia Chemical Co., which will be of interest as showing how an approved product becomes far-reaching in its work:

New York City, N. Y.,
888 W. 55th St., Nov. 2, 1892.

Gentlemen:—The Antikamnia which you sent for use in the North Greenland Expedition, I used with gratifyiug results.

For rheumatism, nearalgic pains, as well as the pains which accompany the grippe, it has no equal.

Yours respectfully,
F. A. Cook, M. D.
Surgeon and Ethnologist of the North Greenland Expedition.
—*Notes on New Remedies.*

Obstetrics.

Twin Pregnancy of Unusual Interest.—Dr. W. S. Stewart, *Annals of Gyn. and Pæd.*, reports the following: Mrs. R., a primipara, was attended by me this summer. There were no special symptoms during gestation, except a little more general discomfort than occurs ordinarily during the same period. In making a preliminary examination previous to her confinement, there was only one fœtal heart sound audible. Still her size and discomfort caused a suspicion on our part that there might be more than one fœtus in utero. After a long and difficult labor we were permitted to deliver her of a large child (weighing about ten pounds), which was asphyxiated in the birth.

Shortly afterward, in examining the abdomen with the intention of removing the placenta, we found there was a hard resisting body in the right upper corner of the uterus, which, on investigation, internally proved to be another undeveloped fœtus, confined in the locality mentioned. Without considering the possibilities of this existing fœtus, being more anxious and concerned for the already exhausted mother, I ruptured the membranes without delay, and forced a rapid delivery of the remaining contents, which proved to be an immature living fœtus of from six to seven months' gestation, weighing about two pounds, and, strange to narrate, still alive, nearly two months old.

To summarize the peculiar features of this case we have:

(1) An increase of the usual discomfort of the expectant mother during gestation.

(2) The lack of power of the divided uterus to expel the first fœtus.

(3) Entire, distinct and separate placentæ.

(4) The difference of time in the conception and development of the two separate ovules.

Gynæcology.

Intra-Uterine Injection of Glycerine.—The injection of glycerine into the rectum has for some years been current in practice, and it is recognized in certain conditions to be a very convenient and efficient method of administering an enema. It strikes me as strange that a substance so efficient in emptying the rectum should until now have been put in comparatively few trials in emptying the uterus of its contents, for *a priori* it seems a likely agent for this purpose. M. Pelzer records some observations made in the latter direction, and speaks favorably of intrauterine injections of glycerine for the inducing of necessary premature labor as well as in cases of insufficient uterine contraction. His method of procedure is as follows: He takes a syringe of the capacity of one hundred and fifty grammes, or a little over four ounces, and, having filled it with pure glycerine, he attaches it, through the medium of a gutta-percha tube, to a perforated sound. Having cleared the apparatus of air in the usual way, he introduces it into the uterine cavity between the posterior wall and the membranes to the fundus of the organ. The glycerine is then injected and the pelvis elevated to prevent its too rapid escape. In a very brief space of time energetic contractions are set up. The effect of the glycerine is due in part to its mechanical action in separating the membranes from the uterine wall and in part to its chemical affinity for water, by virtue of which some of the amniotic liquid is abstracted, which in turn contributes to a further detaching of the membranes. On the whole M. Pelzer was pleased with his results and suggests glycerine as worthy a further trial in obstetric practice.—*Lancet.*

Results of Gonorrhœal Infection in Women.—Von Rosthorn, in the *Prager Medicin Wochenschrift*, 1892, states that the prognosis of gonorrhœal infection is favorable as long as the poisonous process does not invade the cervix. When this happens, rapid extension of the inflammation results, a "gonorrhœa" causing marked changes in the genital tract and surrounding tissues, with special preference for endometrium and tubes. The dependent portion of the pelvic peritoneum also becomes involved. There may be latent gonorrhœa, that is without acute stage and insidious in its development. Later this may become an ascending gonorrhœa with its adverse consequences. It is possible to cure the infectious disease itself, but uterine catarrh and adhesions remain, starting up morbid processes at each menstrual epoch. In regard to accidents connected with the puerperal state, the author does not consider gonorrhea as important a factor as Sægener does. In the acute stage applications of tannin and iodoform to the vaginal mucous membrane are recommended, and injections of bichloride of mercury, one part to one thousand. Cauterizations of the cervix with fuming nitric acid can also be employed, but intra uterine medication is to be avoided. In the latter stage of infiltrations, adhesions, and cicatrices that cause pain, massage, according to the Thure Brandt method is of great value, together with the intra-uterine galvano caustic. Observations based upon one hundred cases lead to the belief that removal of the tubes will always result in almost permanent freedom from pain. These cases have to be watched constantly after the operation, to insure the prophylaxis of ascending gonorrhœa.—*Medical Record.*

Hygiene.

Tobacco as a Protective from Cholera.—The Hygienic Institute of the University of Berlin, has published the following conclusions, after repeated experiments made with relation to the spread of the cholera germ through cigars and tobacco:

The comma bacilli of cholera Asiatica die through drying up on dried tobacco leaves even quicker than through drying up on glass, and in this condition they die in an hour on the average. On moist tobacco leaves the comma bacilli do not increase, and are killed after a short time. The comma bacilli were not proved to exist in the examples of cigars manufactured in Hamburg during the prevalence of the epidemic. Through the fermenting and drying processes which cigars must undergo before they are ready for shipment, the cholera bacilli are killed after a short time, even when packed by way of experiment in the linen bands about the cigars. Tobacco smoke checks the development of cholera bacilli and is quickly fatal.—*Medical Age.*

Diseases of Children.

The Cry in the Diagnosis of Diseases of Children.—The cry of children, according to Dr. E. C. Hill (*Denver Med. Times*), in pneumonia and capillary bronchitis is moderate and peevish and muffled, as if a door were shut between child and hearer. The cry of croup is hoarse, brassy and metallic, with a crowing inspiration. That of cerebral disease, particularly hydrocephalus, is short, sharp, shrill and solitary. Marasmus and tubercular peritonitis are manifested by moaning and wailing. Obstinate, passionate, and long-continued crying tells of earache, thirst, hunger, original meanness, or the pricking of a pin. The pleuritic is louder and shriller than the pneumonic, and is evoked by moving the child or on coughing. The cry of intestinal ailments is often accompanied by wriggling and writhing before defecation. Exhaustion is manifested with a whine. Crying only, or just after coughing, indicates pain caused by the act. The return or inspiratory part of the cry grows weaker toward the fatal end of all diseases, and the absence of crying during disease is often of graver import than its presence, showing complete exhaustion and loss of power. Loud screaming sometimes tells of renal gravel.

Materia Medica.

A New Substitute for Cocaine.—The acetanide of eugenol—which is contained in oil of cloves—has recently been prepared; it occurs in crystalline form,

and appears to enjoy the property of producing local anæsthesia in a very high degree. It may be used similarly to cocaine for this purpose, and, as it has no caustic action and is an energetic antiseptic, it may be found to be even superior to cocaine for minor operations on the mucous membranes.—*Lancet.*

Toxicology.

A Case of Acute Codeine Intoxication.—Medvei (*Internationale klin. Rundschau*, 1892, No. 36, p. 1457) has reported the case of a woman, forty-two years old, of profoundly neurotic tendencies who took 7½ grains of codeine with suicidal intent. For a half hour the patient presented no unusual manifestations, unless perhaps for uncommon cheerfulness and mirth. At the end of this time, however, she complained of a sense of heat, of suffocation, of restlessness, and of vertigo. Soon, mental excitement, itching, and redness of the skin were superadded. The conjunctivæ were injected; the pupils were full and reacted sluggishly to light. Saliva dribbled from the open mouth and the tongue was shaken with tremor. The muscles of the face and extremities twitched convulsively. The knee-jerks were exaggerated, although there was no response to pressure or pricking. The pulse was 46 in the minute, full and hard. The contents of the stomach were evacuated by means of luke warm water, copper sulphate, and a stomach pump. The pulse subsequently rose to 116 and became feeble and soft. Mechanical irritability was now greatly increased. The deep reflexes were greatly exaggerated. The pupils were dilated to the utmost. The pulse grew weaker and cyanosis developed, so that artificial respiration and stimulation became necessary. After vigorous treatment, continued for several hours, the condition of the patient improved and the danger of a fatal issue was averted. On the following day the patient slept a good deal, but was easily aroused. A day later she complained of headache, of mental confusion, and of intense itching.—*Progress.*

Mental Disturbance from Sulphur Compounds.—Dr. B. W. Richardson has a very suggestive editorial in the *Asclepiad* for the third quarter of 1892 upon the effect of mercaptan or sulphur alcohol upon the nervous system and mind. A person brought under its influence has a desire for sleep, a strange, unhappy, dreamy sensation as from some actual or impending trouble, succeeded by an extreme sense of muscular fatigue, so that the limbs feel too heavy to be lifted, with depression and slowness of pulse—effects lasting for several hours until the sulphur is eliminated. These experiments were conducted in 1870. He further noted, at that time, that this and other sulphur compounds might be readily constructed in the living animal tissues, and that there was opened to physicians a new field of inquiry relative to the presence of sulphur in the expired air or other excretions of patients. He believes that the breaking up of albuminous textures in disease is often attended by the formation of volatile sulphuretted organic compounds. Remembering how minute a proportion of sulphur alcohol will produce mental depression bordering upon suicidal propensity, it might be inferred that the formation of sulphur compounds of this character in the body would account for many examples of excessive temporary prostration. In a further research he came to the conclusion that the influence exerted over nervous matter by the element sulphur, in disintegration, was so marked in mental aberration that it was inevitable that melancholia and other nervous affections, attended with or without paralysis of voluntary muscles, must some day be ascribed to the presence of compounds of this element; that there was abundant evidence from odor alone of the presence of mercaptan in the excretions from the lungs, the skin and the alimentary canal, and that here were indications for a rational explanation of insane conditions produced as deliriums from intoxication by poisons developed in the vital organic chemistry.—*N. Y Med. Journal.*

Death from Cocaine.—Richardiere records an accidental death from this drug, and states that he has made autopsies in eleven cases in which death has resulted from the injection of cocaine. In his case death followed the injection of half an ounce of a one and one-half per cent solution of cocaine into the tunica vaginalis testis, preparatory to the injection of iodine for the cure of hydrocele.

The solution of cocaine was withdrawn after less than a minute and the iodine injected. In a little while the patient returned, complained of great weakness, had clonic and then tetanic convulsions, became comatose, and died with cardiac syncope.

At the autopsy there was found general congestion of the meninges and lungs, mitral insufficiency and alcoholic lesions in the viscera. The tunica vaginalis did not communicate with the peritoneal cavity. —*Boston Med. and Surg. Journal.*

Pathology.

Syphilis and General Paralysis.—The relationship of the luetic process to paretic dementia, so often discussed by alienists, has recently received further consideration by several authors. Among others, E. A. Homén has described a peculiar typical disease in three sisters in the form of a progressive dementia accompanied by extensive vascular changes which indicated hereditary syphilis (*Arch. f. Psychiatrie und Nervenkrankheiten*, xxiv., 1).

Commenting upon this, Sommer advanced the hypothesis that all cases of tabes and progressive paralysis not due to individually acquired syphilis must be considered as endogenous degeneration from hereditary syphilis (*Ctrlbl. für Nervenheilk. und Psych.*, October, 1892).

Jacobson, of Copenhagen (*Jour. of Ment. Science*, April, 1892), presents the statistics of one hundred cases of general paralysis in women, in thirty-seven per cent of which syphilis was certainly present, and in all probability sixty-five per cent were really suffering from this disease. Comparing this with other ætiological factors, such as alcoholism (twenty-seven per cent), and heredity (twenty-eight per cent), he decides that syphilis is by far the most important cause of paralytic dementia.

Œbeke, of Bonn (*Zeitschr. f. Psych.*, xlviii), found fifty-seven per cent of his cases of general paralysis to be syphilitic, whereas only twelve per cent of all other forms of insanity had a luetic origin.

Dr. H. M. Bannister (*Jour. of Nerv. and Ment. Dis.*, December, 1891), in an ætiological analysis of two hundred and thirty-four cases of general paraly-

sis, found over seventy per cent of the patients undoubtedly affected with syphilis, and adding cases where lues was probable though not certain, the percentage was increased to nearly eighty-nine per cent. Over fifty of those that were infected with syphilis were also intemperate. The author looks upon syphilis and alcohol as the most frequent antecedents of paralytic dementia.

The reviewer has pointed out (*Medical Record*, May 21, 1892,) that in Egypt where there is no more common disease than syphilis, there are no cases of general paresis to be found among the native Egyptians at all—a fact that should lead us to be slow in regarding this process as the leading ætiological factor in paralytic dementia, and particularly to avoid giving too much credence to the rather remarkable hypothesis of Sommer's noted above.—*New York Medical Journal.*

MISCELLANEOUS.

MEMORIZING DOSES.—Dr. G. A. Wiggins gives the following rules:

1. The dose of all infusions is 1 to 2 ounces, except infusions of digitalis, which is 2 to 4 drachms.
2. All poisonous tinctures 5 to 20 minims, except tincture of aconite, which is 1 to 5.
3. All wines, from ½ to 3 fluid drachms, except wine of opium, which is 5 to 15 minims.
4. All poisonous solid extracts you can give ½ grain, except extract of calabar bean, which is 1–12 to ¼ grain.
5. All dilute acids, from 5 to 20 minims, except dilute hydrocyanic acid, which is 2 to 8 minims.
6. All aquæ, from 1 to 2 ounces, except aqua laurocerasus and aqua ammonia, which are 10 to 30 minims.
7. All medicated syrups you can give 1 drachm.
8. All mixtures, from ½ to 1 fluid ounce.
9. All spirits, from ½ to 1 fluid drachm.
10. All essential oils, from 1 to 5 minims.—*Pharm. Record.*

ICTERUS OF MENTAL ORIGIN is said by Prof. Potain to be produced as follows: A vivid mental impression, by acting on the abnominal plexuses, may produce a paralytic dilatation of the blood vessels of the liver, in consequence of which the pressure is suddenly lowered in the hepatic circulatory system. Now, if the pressure in the neighboring bile ducts be not simultaneously modified, exosmosis may be established from the latter toward the former, whereby bile is made to pass into the blood. Hence the icterus.—*Merck's Bulletin.*

IS EVOLUTION TRYING TO DO AWAY WITH THE CLITORIS.—Dr. Robert T. Morris, of New York, read before the American Association of Obstetrics and Gynæcology, a paper upon the above subject and presented photomicrographs and sections of anatomical specimens in support of his proposition. The summary of his paper was as follows:

1. The prepuce and the glands clitoris are bound together by adhesion, partly or completely, in about eighty per cent of all white American women.
2. Such preputial adhesions are rare among negresses, and apparently occur only in a few individuals possessing a large admixture of white blood.
3. Highly developed domesticated animals do not present examples of this degeneration, judging from a fair collection of data bearing upon the subject.
4. When preputial adhesions are extensive the glands clitoris and the imprisoned mucous glands remain undeveloped, but they may develop later when the physician has separated adhesion.
5. The failure of the embryonic genital eminence to properly develop the prepuce and glands clitoris for perfect cleavage probably means that nature is trying to abolish the clitoris as civilization advances.
6. The degenerative process represented by preputial adhesions is characteristic of the civilized type of *homo sapiens* in which we find decaying teeth, early falling hair and imperfect corneas and eye muscles.
7. Preputial adhesions which involve small portions of the glands clitoris are of interest simply as anatomical curiosities.
8. Preputial adhesions involving a large part or whole of the glands clitoris cause profound disturbance, and are among the most pronounced of peripheral irritators. They cause desire for masturbation, which leads to neurasthenia, and they are responsible for grave reflex neuroses.
9. Preputial adhesions probably form the most common single factor of invalidism in women. The clitoris is an electric button which pressed by adhesion rings up the whole nervous system.
10. The physician who neglects to examine the female child for preputial adhesion neglects the most important single duty of his professional life.—*Medical World.*

METHOD OF POULTICING.—Poulticing an ear may seem to be a simple operation, but there is, nevertheless, a right and a wrong wayof doing it, and it appears that the wrong way is the one usually adopted. At least so says Dr. Albert H. Buck, of New York, in an article on aural therapeutics in the March number of the new *International Medical Magazine.* Dr. Buck says that while heat is one of the best remedies in painful inflammations of the middle ear, and the poultice is one of the best methods of applying heat, as usually put on the poultice has but little effect. What should be done, he says, is first to fill the external auditory canal with lukewarm water, the head resting on the unaffected side on the pillow. Then a large flaxseed poultice is applied over the ear as hot as can be borne. The column of water is thus kept warm and acts as a conductor of heat between the poultice and the inflamed surface.—*N. W. Lancet.*

THE MICROBE OF SOFT CHANCRE.—Drs. Iningwand and Nicolle reported, at a meeting of the French Society of Dermatology and Syphilography, held July 7, 1892, that they had succeeded in coloring by a special method a bacillus which they believed to be the specific microbe of chancroid, and to be identical with that described by Unna. Their method, which they consider preferable to others heretofore employed, consists in coloring the sections with phenicated methyl blue and hydrates, and clearing them up with aniline oil mixed with xylol. A special form of bacillus is then seen arranged in very numerous and very long twisted chains, occupying the tissue of the excised chancroid. These little cordons are located in the lymph spaces and outside the cells. The aspect of one of the sections is said to be so very characteristic, that a diagnosis may be made at the first

glance. The bacillus is not colored by the Gram method, nor by the ordinary process of Kühne. Culture trials have been made without success, and the results of inoculation experiments in animals have also been negative.—*Medical Record.*

DIET IN DIABETES.—The following rigorous diet is recommended by Dujardin Beaumetz, of Paris: Eggs, fish, meats of all kinds, poultry, game, oysters, fish and cheese.

All green vegetables are permitted except beets, carrots and beans.

Fatty foods are recommended, such as sardines in oil, herring, lard, goose grease, ham fat, and caviar.

All soups are permitted, when made of meats in combination with cabbage, poached eggs and onions. Put no bread or toast in the soup.

Only dietic breads are to be used and saccharine in place of sugar.

All starch foods are strictly forbidden, as sweet fruits, pastries and chocolates.

Patients may drink claret wine diluted with Vichy, but no poor wines, liquors or spirits.

Daily exercise morning and evening in open air; fencing and gardening and other light exercise.—*Medical Mirror.*

THE MORPHOLOGY OF BREAST MILK AND THE NUTRITION OF THE CHILD.—An extensive study by Ivanhoff (*Thése de St. Petersburg, 1890*) of this subject, led him to the following conclusions:

1. The cellules of colostrum are of epithelial origin.
2. The multiparæ colostrum changes to milk more rapidly than in primiparæ.
3. Puerperal diseases retard the disappearance of the colostrum corpuscles.
4. These corpuscles reappear in the milk after ten months of lactation, and when the infant is only partly fed from the breast.
5. The free hyaline corpuscles, as well as those which are enclosed in the fatty globules, form a constituent of normal milk at a certain period of secretion.
6. Good health, good nutrition, and youth in the mother give a milk richest in fatty globules of large size, as is also true of the cellules.
7. The last portion of milk taken at a feeding holds fewer globules, and these of smaller size than the first portions.
8. The estimation of the nutritive quality of milk should be based upon the number of fatty globules; and, secondarily, upon their size, the quantity of cellular element, and, finally, upon the quantity of granules.
9. Milk which contains a very large number of fatty globules (more than 3½ per cent) is not well borne by very young infants.
10. Milk, the globules of which are large, is less nutritive and less well borne.
11. The maximum of daily increase of weight of the child is produced by milk which contains a mean quantity of fatty globules of medium size (27.7 grammes daily.)
12. The milk which contains few fatty globules gives little increase of weight (sixteen grammes daily); and the same is true if the fatty globules are in too great quantity or are too large (nineteen grammes).
13. Women who are thin and young in general are the poorest nurses, often making the children dyspeptic and giving them a mean daily increase of weight of only 11.5 grammes.
14. The microscopic examination of a freshly secreted milk gives a sure indication of its nutritive value.—*Med. and Surg. Journal.*

THE LATEST ANALYSIS OF THE KEELEY CURE.—Hydrochlorate of apomorphine is said to be the agent responsible for all the ill effects of the Keeley "bichloride of gold" cure. This we have on the authority of one who has compounded large amounts of the whisky employed as an adjuvan to the cure. The feeling of nausea and sickness which follows each dose of the whisky as supplied by the Keeley cure people is ascribed usually to the action of the atropine and strychnine contained in the fluid employed for hypodermatic injection, and no one has ever suspected that the fits of trembling, symptoms of paralysis, and general collapse which develop in so many of the "victims," are due to aught but the effects of the injected fluid, or the natural consequence of the withdrawal of alcoholic stimulants from a person whose system craves the stimulating effects of alcohol. To illustrate the dangerous nature of the drug, we quote Hare, who says that Reichert found that apomorphine hydrochlorate in poisonous doses produces convulsions and finally paralysis which is spinal in its orgin. "On the nervous centers in this brain apomorphine acts as a stimulant. * * The motor and sensory nerves are finally paralyzed, and even the muscles become poisoned and incapable of contraction."

Each ordinary dose of the whisky is said to contain one-fiftieth grain of apomorphine; and, as one-tenth grain of the drug is necessary to produce emesis, it can be easily understood in what manner the decoction acts.—*Pharmaceutical Record.*

SOCIETY PROCEEDINGS.

Gynæcological and Obstetrical Society of Baltimore, November Meeting.

The President, Dr. B. B. Browne, in the chair.

DR. GEORGE H. ROHE, read a paper entitled "Gynæcological work among the insane."

The subject was treated under three heads:

1. Is it necessary?
2. Is it practicable?
3. What are the results?

To show the necessity of the work it was stated that of thirty-five insane women examined, twenty-six or 74.3 per cent showed some evidences of pelvic disease or abnormality. The lesions found were mostly tears of the perineum or cervix, uterine displacements and adhesions, adhesions of the tubes and ovaries, cystic ovaries, parovarian cysts, etc.

Dr. Rohe expressed the belief that a careful examination by a competent gynæcologist would show that at least fifty per cent of all insane women had some form of pelvic disease. This large percentage of diseased pelvic organs among the insane certainly indicated the necessity for gynæcological treatment among this class of patients.

That this work can be successfully carried out among insane women is evidenced by the report of

eighteen cases of abdominal section with removal of the tubes and ovaries. The patients were affected with the various clinical forms of mental disturbance: melancholia, mania, periodic mania, hysterical mania, puerperal insanity, epileptic insanity and hystero-epilepsy.

The duration of the insanity in the various cases was from one month to eleven years. In all but one case the insanity had lasted over a year, and in very few were there any good prospects of recovery under the usual management.

At the date of reading the paper, three of those operated upon had been discharged recovered, and in ten there had been decided improvement in physical and mental symptoms. Two had died after the operation, one from sepsis, and one in *status epilepticus*.

These results are believed by Dr. Rohe to justify the prosecution of gynæcological work among the insane. The plea is made that the insane woman is as much entitled to relief from physical ills as is her sane sister. No argument beyond the recital of the facts should be necessary to enforce this view.

Dr. William P. Chumm. I have operated upon two cases of hystero-epilepsy, in both I removed the ovaries. Both recovered from the operation and both were improved in general health. I would be very loath to operate upon any case where examination failed to discover to the touch appreciable disease. It is well to differentiate between epilepsy and hysteria. The former is in my opinion incurable. If a woman is made peevish, irascible and melancholy or unreasonable from pain or the dread of pain, she may be called nervous or hysterical, but this is not epilepsy.

Personally I would not take out ovaries or tubes for hysteria or epilepsy unless disease could be demonstrated before or at the time or operation.

Dr. Wilmer Brinton. I have seen three cases of puerperal insanity in private practice; they were treated for a while at home, but they became so violent the families were compelled to send them to an institution for the insane. All three cases died there, and their deaths occurred within ninety days after delivery. I believe that the greater number of cases of puerperal insanity result from septic inoculation at the time of delivery, or from some lesions of the genital tract.

Dr. Thomas Opie: Dr. Chumm has remarked upon the fact that in several of Professor Rohe's cases, there was no pathological state of the ovaries discovered, and that therefore the operation for their removal was contraindicated.

There are occasionally met with cases when our manual explorations reveal no physical change in these organs, and yet their functioning is disordered in the most positive way.

The following case will serve to illustrate my point:

M. R.——, age thirty-one, single. Menstruation began at thirteen, and continued regularly and without pain until some time between sixteen and eighteen years of age, when she first manifested a condition of delirium at her monthly periods. Her abnormal menstruation was persistent. When between twenty-five and twenty-six years her menstruation was accompanied by still more pronounced disturbance of this function and greater mental alienation in the way of inability to concentrate her thoughts and a confusion of ideas. When at the age of twenty-eight, there was observed at her periods a twitching of the lower limbs, a short time before the appearance of her flow. This lasted during its continuation and for a week afterward.

With each recurrence, these attacks increased in severity gradually involving the upper extremities in clonic spasms. A year prior to operation she began to lose consciousness during the attacks. Occasionally between her periods she had muscular twitching, which always passed off in a few hours. Until this time, the invalid had been able to attend to light duties in connection with her home.

For eight months prior to operation, she was totally disqualified for all duties, mental and physical, indeed was bedridden.

Upon admission to the hospital, May 18th, she was in a most debilitated and anæmic state physically, associated with well-marked mental aberration. Her look was confused; there was momentary stupor, she became convulsed, her head was thrown back, muscles were rigid, pupils contracted, skin moist, urinary secretions scanty, respiration increased, temperature normal. When the attack was over, she stated on being interrogated, that she remembered nothing about the attack.

An oophorectomy was performed May 21st. The ovaries were found to be relatively small and perfectly normal. June 9th no recurrence of spasms, her mind clear and active. June 27th patient has entirely recovered from operation and has no neurotic symptoms. Five months have elapsed since the removal of the ovaries. She is restored mentally and physically to a state of health.

There was no neurotic family history in this case. Her troubles began coincidently with her earliest menstruation. At first they simulated the aura. The attacks accompanied her ovulation for eighteen years —growing year by year worse, until she was upon the brink of ruin, both as to mind and body.

The ovaries on removal gave all the appearances of being normal.

Dr. J. Whitridge Williams: I have listened with interest to the conservative views expressed by Dr. Ashby regarding the removal of the uterine appendages for psychical disorders, and wish to add my voice to his in condemning the indiscriminate castration of women under all sorts of pretexts. Unless we are able to diagnose a pathological lesion of the tubes and ovaries, we should not think of attempting to remove them either for the relief of pain or as an experimental measure in psychical disorders. For it is only when they present a marked pathological lesion that we can be at all sure of our results after operation, and we are liable to be accused of reckless surgery if we remove apparently normal organs purely for the cure of some evil, of whose cause we are yet in ignorance.

Recent work on the nerves of the ovary gives us more of a basis upon which to base the doctrine of reflex ovarian disturbances; for von Herff has shown that the ovary contains nerves, which supply all parts of the organ. These are so abundant that he states that they not only are present in large quantities, but that they may be said to compose a considerable portion of the bulk of the ovary.

William S. Gardner, *Secretary*.
613 Park Avenue.

He: How the trees are moaning and sighing today.

She: So would you if you were as full of green apples as they are.—*Life*.

Book Reviews.

"The Principles and Practice of Bandaging." By Gwilm G. Davis, M. D., University of Pennsylvania and Gottingen. Member of the Royal College of Surgeons, England; Assistant Demonstrator of Surgery, University of Pennsylvania; Surgeon to Out-Patient Departments of the Episcopal and Children's Hospitals; Assistant Surgeon to the Orthopædic Hospital. G. S. Davis, Detroit, Mich.

The object of this work is to direct attention to the fundamental bandages and to the importance of first learning principles, and then to their application in the form of the various special bandages. Good results in fractures and efficacy in surgery depend largely upon bandaging and enough attention is not always paid to this point. This work does not go deeply into the literature of bandaging, and quotations are only given when necessary to elucidate the subject. Some of the bandages described have been devised by the author of the book, but he does not claim originality, as the many given in large text-books has led him to the belief that there is no new thing under the sun. The student and practitioner will find much to interest him in this work, on account of the concise method of its arrangement.

"Pye's Surgical Handicraft." A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the Work of House and Surgical Dressers. With 300 illustrations on wood. First American from the Third London Edition. Revised and Edited by T. H. R. Crowle, F. R. C. S., Surgical Registrar to St. Mary's Hospital; and Surgical Tutor and Joint Lecturer on Practical Surgery in the Medical School. Complete in one volume. New York: E. B. Treat, 5 Cooper Union. 1892.

This is a very complete and satisfactory work on minor surgery, bandaging and surgical manipulations, and dressings, and is intended to describe the details of surgical work, as it appears from the point of view of house surgeons or residents in a hospital.

The following subjects are very fully considered and ably elucidated: Hæmorrhage and its Arrest; Bandages; Splints, etc.; Fractures; Wounds, Ulcers, Burns, etc.; Cases Requiring Prolonged or Mechanical Treatment; Certain Emergencies, Surgical and General; Anæsthetics; Extraction of Teeth and Management of Aural Cases; Minor Surgery and Kindred Subjects; and an Appendix with Formulary of Lotions, Ointments, Liniments, Caustics, Dusting Powders, Suppositories, Hypodermic Injections, Fomentations, Sprays, etc.

This book does not enter into long discussions on special points, but the student is referred to foot notes, where references are given to a number of different authorities. The medical student and hospital interne will find this work a very valuable addition to his list of text-books, on account of the concise arrangement and array of surgical facts.

"Book on the Physician Himself, and Things that Concern His Reputation and Success." By D. W. Cathell, M. D. New Tenth Edition (Author's Last Revision). Thoroughly revised, enlarged, and rewritten. In one handsome Royal Octavo volume. 348 pages. Bound in Extra Cloth. Price, postpaid, $2.00, net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert Street.

The fact that this is the author's tenth edition of this work, evinces the marked favor with which his work has been received by the medical press and members of the medical profession. The last issue has been carefully revised, and a great deal of new material added making a work of some 340 pages. To those who have had previous editions of the work no words will be needed, but to those who have not yet examined its pages, we say in the words of the quotation used by the writer himself, "Turn to the right, then go straight forward.

"All Around the Year, 1893." Entirely new design in colors, by J. Pauline Sunter. Printed on heavy cardboard, gilt edges, with chain, tassels, and ring. Size, 4¼x5½ inches. Boxed. Boston: Lee & Shepard.

The calendar like its predecessors is a very charming piece of work, the designs being quaint and picturesque. The twelve cards are done in several colors, each bearing an entirely different picture, and the whole forming a little love story.

"The Mediterranean Shores of America: or, The Climatic Physical, and Meteorological Conditions of Southern California." By P. C. Remondino, M. D., Member of the American Medical Association, of the American Public Health Association, of the State Board of Health of California; Vice-President of the California State Medical Society, and of the Southern California Medical Society. Illustrated with forty-five engravings and two double-page maps. In one handsome royal octavo volume, 176 pages. Extra cloth, price, $1.25, net; cheaper edition, bound in paper, price, 75 cents, net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert street.

Much has been written and said regarding the climate of California as a health resort, and the above book is really a comprehensive consideration of Southern California, with reference to this subject. Dr. Remondino has endeavored to give us a work that will be advantageous to those who desire to be correctly informed concerning the resorts, and also explains at some length that care and prudence on the part of the patient is very essential in addition to the climatic effects. The work is not only well written, but instructive and entertaining as well.

"Annual of the Universal Medical Sciences, 1891." A yearly report of the progress of the general sanitary sciences throughout the world. Edited by Charles E. Sajous, M. D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators and correspondents. Illustrated with chromo lithographs, engravings and maps. In five octavo volumes of about 540 pages each. 1892. The F. A. Davis Company, Publishers, Philadelphia, New York, Chicago, and London. By subscription. Price for the five volumes, $15.

The Annual of the Universal Medical Sciences for 1892 has been received and is undoubtedly the best of the series yet issued. These Annuals enable one to place in his library, a full and concise compilation of the results of progress in the entire field of medical science and research for the preceding year. The work has been most carefully edited by Dr. Sajous and among his collaborators will be found the names of many of our most eminent writers and observers. The standard adopted in and maintained in former series has been kept up in this fifth series, and a conscientious attempt made to advance in the excellence of the work.

By an examination of the index some idea of the immense amount of work necessary for the completion of these volumes may be gathered. Quoting from the preface, the editor states, "The Annual by no means pretends to have reached the point of excellence that it is hoped it will some day attain. A conscientious attempt to make it advance as rapidly as possible has been made, but many are the shortcomings to be conquered and the developments still to be evolved. A prolonged sojourn in Europe,

contemplated by the editor, will, it is hoped, open many new channels calculated to widen the scope of the work and increase the sphere of its usefulness.

If no improvements are announced this year, it is because the fountain of useful suggestions has apparently become exhausted. Justice has been done to all those offering the best evidence of advantage to the readers. Many others could not be entertained without risk of sacrificing material of much greater importance than the proposed improvement."

No one in the medical profession can afford to be without these annuals in his library, as they contain a mass of information compiled in such a convenient form, as to be of invaluable aid to the busy practitioner.

The International Medical Annual and Practitioners' Index for 1892. Edited by P. W. Williams, M. D., Secretary of Staff, assisted by a corps of thirty-two collaborators—European and American—specialists in their several departments. 644 octavo pages; illustrated; price, $2.75. E. B. Treat, Publisher, 5 Cooper Union, New York.

Part I. comprises the New Remedies, together with an extended review of the therapeutic progress of the year.

Part II. is given to the consideration of New Treatment, and is a retrospect of the year's work, with numerous orignal articles by eminent authorities.

Part III.—the last part—is made up of miscellaneous articles, such as Recent Advances in Bacteriology, Medical Photography, Sanitary Science, Use of Suppositories in the Treatment of Disease, Improvements in Pharmacy, New Inventions in Instruments and Appliances, Books of the Year, etc.

The tenth yearly issue of this one volume reference work has been received, and is of incalculable value as a faithful record of the progress of the medical sciences for the year. The best writers have contributed toward making this edition better than any previous ones, and no one can peruse a single portion of the book without being thoroughly impressed with the way the work has been executed. Numerous illustrations, some of which are colored, add much to the attractive features of the annual, and as the whole is a medical encyclopædia we would advise those wishing much information for a small outlay, to add this book each year to their medical collection.

"Sleep, Insomnia, and Hypnotics." By E. P. Hurd, M. D. Published by George S. Davis, Detroit, Mich. 1892. Price, 25 cents, paper; 50 cents in cloth.

This valuable contribution to the Physician's Leisure Library Series, is worthy of careful reading, being not only a translation of the essay of Germain Sée, on insomnia and hypnotics, but revised and enlarged by Dr. E. P. Hurd, producing an original monograph in the form of an interesting and practical consideration of the subjects. The book contains the physiology of sleep, the etiology and pathology of insomnia, as well as the philosophy of its treatment, together with a chapter on hypnotics of inestimable value to physicians who prescribe drugs carelessly. The book is well worth reading.

"Bright's Disease of the Kidneys; Its Pathology and Diagnosis." By Henry B. Millard, M. A., M D., with numerous original illustrations and chapters on Anatomy of the Kidney, etc. Third edition revised and enlarged. Published by Wm. Wood & Co.

The appearance of the third edition has been awaited with much pleasure by those fortunate to obtain the previous editions of this work. Much new matter has been added, together with observations and investigations, some chapters being entirely rewritten.

It is a very comprehensive work on the subject of Bright's disease, and as it shows the results of twenty-six years of hospital and private practice, will be of great value to the physician in aiding him to diagnose and manage from the foundation, the pathology and treatment of this very common affection, and aid him in benefiting not only curable cases, but those also which seem but little hopeful. The book contains numerous original illustrations which add to the practical value of the work.

Text-Book of Nervous Diseases, being a Compendium for the Use of Students and Practitioners of Medicine. By Charles L. Dana, A.M., M.D., Professor of Nervous and Mental Diseases in the New York Post-Graduate Medical School, and in Dartmouth Medical College; Visiting Physician to Bellevue Hospital; Neurologist to the Montefiore Home; ex-President of the American Neurological Association, etc. With 210 illustrations. Octavo, 524 pages, red parchment muslin, price, $3.25. William Wood & Co., New York.

This is one of the most scientific works on diseases of the nervous system that has been issued through the American press. The science of neurology is presented in a concise and complete form, each subject taken up, all the available facts ascertained regarding it, and then the writer has added his own experience, furnishing a chapter of great value to the student and practitioner, and also to the specialist. The extreme importance of a knowledge of anatomy has led the writer to pay especial attention to modern neuro-anatomy.

For the physician in general practice, and for the student in college, we know of no single volume on Nervous Diseases that will give him so much information in so concise a manner as the above work.. We take pleasure in recommending it to the profession.

Medical Microscopy. A Guide to the Use of the Microscope in Medical Practice. By F. J. Wethered, M. D. (London), Member of the Royal College of Physicians; Medical Registrar to the Middlesex Hospital and Demonstrator of Practical Medicine to the Middlesex Hospital Medical School; Late Assistant Physician to the City of London Hospital for Diseases of the Chest, Victoria Park, with Illustrations. Published by P. Blakiston, Son & Co., Philadelphia.

As the microscope has been gradually brought more and more into use in medical practice as an aid to diagnosis, in certain classes of diseases, especially those of the chest and urinary organs, the issuing of such a work as this has become a necessity. In this volume an effort has been made to lay before the practitioner and student the most simple methods of preparing microscopical sections, and of the examination of urinary deposits, sputa, blood, etc. Chapters have been added on the examination of food and bacteriological methods, and a chapter on "tumors" inserted for the purpose of diagnosis in examinations in the operating or post-mortem room. The book is well illustrated, and will be a great help to the use of the microscope, especially by those who have previously given this instrument but little study.

"Acne and Alopecia." By L. Duncan Buckley, A. M., M. D., Professor of Diseases of the Skin, New York Post-Graduate Medical School; Physician to the New York Skin and Cancer Hospital, etc. 25 cents a copy. Detroit: Geo. S. Davis.

The little book of 84 pages, is one of the volumes of The Physician's Leisure Library Series, and deals with a subject with which every physician

should be familiar. It would be difficult to find a better memorandum of all the essential features and treatment of acne and alopecia than this work, as it is given to the reader in as clear, concise and practical a manner as possible. The author states that the reason the two subjects are given in one volume is the great frequency of the two conditions and the difficulties encountered by the general practitioner in their management.

"Treatise on Diseases of the Nose and Throat." In two volumes. By Francke Hunting Bosworth, A. M., M. D., Professor of Diseases of the Throat in the Bellevue Hospital Medical College, New York; Consulting Physician to the O. D. P. Department of the Bellevue Hospital; Fellow of the Laryngological Association, of the American Climatological Association of the New York Academy of Medicine, of the Medical Society of the County of New York, etc. Volume II. Pp. 845. Illustrated. New York: William Wood & Co.

The medical profession, and especially the specialist in diseases of the nose and throat has awaited with great interest the issuing of the second volume of this work, the first having made its appearance some two and a half years since. The first section of the book is devoted to the consideration of diseases of the fauces, including under that term that region which includes the oropharynx, the soft palate and faucial pillars and the tonsils. The writer states that the term fauces is not perhaps one in general use, yet he has used it to describe in a single expression that portion of the air and food tract which includes the above organs. The second section is devoted to diseases of the larynx, while in the third section the various surgical procedures which are resorted to for obtaining access to the oropharynx and larynx, and which involve cutaneous section. The epidemic of influenza which has spread over this and the European continent, has done much to complicate and add to the diseases of these organs, and for this reason such a comprehensive work as Dr. Bosworth has prepared is of inestimable value to the medical profession.

"A Treatise on Diseases of the Rectum, Anus and Sigmoid Flexure." By Joseph M. Matthews, M. D., Professor of Principles and Practice of Surgery and Clinical Lecturer on Diseases of the Rectum, Kentucky School of Medicine; Visiting Surgeon St. Mary and Elizabeth Hospital; Consulting Surgeon Louisville City Hospital; Consulting Surgeon Jennie Cassaday Free Infirmary for Women; Late President Mississippi Valley Medical Association; President Louisville Clinical Society; Vice President Louisville Surgical Society; Member International Medical Congress, American Medical Association, Southern Surgical and Gynæcological Society, Kentucky State Medical Society, State Board of Health of Kentucky, Orator of the American Medical Association on Surgery, 1891, etc. With six chromo-lithographs and numerous illustrations. D. Appleton & Co., New York.

Dr. Mathews has given to the profession a decidedly original book on the above, recording his individual experience of fifteen years as a rectal specialist. He says in his introduction "During this time I have learned that many things that are taught are not true, and that many true things have not been taught. I have not taken other men's opinions as my guide, but have accepted as truths only those things which could be substantiated by fact, and here recorded them."

Several chapters new to books on this subject have been introduced by him, among which will be found the following: Disease in the Sigmoid Flexure; The Hysterical or Nervous Rectum; Anatomy of the Rectum in Relation to Reflexes; Antiseptics in Rectal Surgery; a New Operation for Fistula in Ano. In this chapter will be found a description of the instrument fistulotome, for which the writer claims priority in the treatment of this disease.

The work is well illustrated, and among the plates will be found six chromo lithographs. Clearly printed with large type, and nicely bound, it appears very attractive, and is a work that will meet the approval of the student and practitioner, and become popular at once upon examination.

"International Clinics." A Quarterly of Clinical Lectures on Medicine, Surgery, Genæcology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology and Otology. Edited by John M. Keating, M. D., LL. D., Colorado Springs, Colo.; Judson Daland, M. D., Philadelphia; J. Mitchell Bruce, M. D., F. R. C. P., London, England; Daniel W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland. Volumes I. II. and III. Second Series. 1892. Philadelphia: J. B. Lippincott Company.

The International Clinics are without doubt a series of books valuable in their contents to every member of the medical profession, whether a specialist or general practitioner. The teachers of Europe as well as America have contributed their best thoughts and concise practical experience in such a way as to enable every careful and studious practitioner to keep himself up with what is going on in the medical profession. Every subject is treated on and each book contains fifty and upward of article from the pens of men who stand at the head of their various specialties. The editors deserve the highest gratitude for the manner in which they have compiled these volumes, the standard of excellence in the first issue having been fully maintained in each succeed ing edition.

"A Practical Treatise on Diseases of the Skin." By John V. Shoemaker, A. M., M. D., Professor of Skin and Venereal Diseases in the Medico-Chirurgical College and Hospital of Philadelphia; Physician to the Philadelphia Hospital for Diseases of the Skin; Member of the American Medical Association; of the Pennsylvania and Minnesota State Medical Societies; of the American Academy of Medicine, and of the British Medical Association; Fellow of the Medical Society of London. Second edition, revised and enlarged, with chromogravure plates and other illustrations. New York: D. Appleton & Co., 1892. Chicago: A. C. McClurg & Co. Price $5.

The second edition of Dr. Shoemaker's work is a decided improvement on the first issue which appeared some four years ago. The author has incorporated various new points relative to etiology, pathology and treatment, and interesting facts pertaining to the clinical history of different affections have been added. A special section on electricity, in which the value of this agent is discussed in the treatment of many diseases of the skin is a very interesting addition. The illustrations are particularly to be complimented upon, especially the frontispiece, giving psoriasis from nature, also the figure of the leprous child.

The work without being exhaustive shows the immense strides the science of dermatology has made of late years, which is particularly a subject upon which every physician wishes to inform himself. Taken as a whole the work is good, practical and reliable.

Pamphlets and Reprints.

"Hereditary Ataxy." By Sanger Brown, M. D., with discussion by J. A. Ormerod, M. D., Oxon., F. R. C. P., and Professor Bernhardt, of Berlin. Reprinted from *North American Practitioner* and *Brain*.

"The Dominant Factor in Talipes, Both the Congenital and Infantile Acquired Forms with Treatment." By A. E. Hoadley, M. D. Reprinted from *Chicago Medical Recorder*.

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

VOL. XV. FEBRUARY, 1893. No. 2.

ORIGINAL ARTICLES.

An Abstract of a Work Covering the Scientific Phases of the Drink Habit and Its Successful Medical Management and Treatment.

BY JOHN G. REED, M. D., SIXTH AND WALNUT STS., CINCINNATI, O.

The tangible ideal character foreshadowed by the past is the perfections of the present embodied and studied by degrees of adaptation in a practical medium without the necessity of the crudity of the present that shock common sense. It may be with the drinking class primarily that the axiom of the survival of the fittest applies in favor of stimulant drinking. Metamorphosis in families is either toward or from the best types of energy, and in change we comprehend a principle of substantial growth seen no less now in seeking the ideal than in the mighty march through instinct up to intellectual consciousness. Having reached to what we are and being the best nature could make us in relation to all the past we certainly should be encouraged to believe that stimulant drink disease will yet be universally disintegrated out by the upbuilding intellectual consciousness. Obviously the best way to cut the world off from its "whisky" would be for each individual to continue to attend to his own business as he sees it and leave the whole matter to the laws of spontaneity. By combining the Napoleons of science could (to their shame in posterity) effect a quick and successful enforcement of a nondrink decree by arousing one-half of the world to largely abandon the more serious affairs of life to madly whip the other half into abstemiousness. The effort would result in civil war and compromise for the sake of humanity. In the readjustment of society the old order of substantial growth would be soon reached by a temporary increase of drunkenness.

The sign of the times points to rapid growth in correct living, not that the masses are the less aspiring to the enervating unproductive monomanisms of high life, but because that cold foresighted army of medical doctors have been awakened by the noise and results of empiricism to put to a severe test the wisdom of science in an endeavor to formulate a treatise for the drink habit. The profession arouses to action the latent and true reform forces in learning when it says stimulant drink disease has a primary, secondary and third stage as well as family history, all of which can be isolated by negative nondrink pathology, morbid physiology and curative results of drug as well as other treatment. The movement is in touch with medical progress, through the ages and at a most vital juncture in general growth, commands bigotry and ignorance to extend the hand typical of our common humanity to the individual sick from drink habit as it is extended in other sickness. The ultra are taking a broader view of the drink habit question and now qualify their denouncement from a feeling of necessity to honestly recognize the law of necessity in human growth, when defining duty and humanity in connection with the drink habit. True reform means that community sympathy shall regard the individual sick from the drink habit as a most pitiable sick man, while the doctor stands between the drinker and persecuting sentimentality and administers the remedies with proper management that will correct morbid physiological causative conditions. Doctors have awakened to something new as the ministers have begun to call in to talk up practical reform from drunkenness.

The rapidity with which drunkenness will check depends upon the energy reform in social ethics will tender to the practical uplifting of the drinking class. Why? Because in the cure of drunkenness the ministry and its auxiliaries, and the medical profession can unite. The drunkenness of the ministry through recent centuries, the extinction of old schools of philosophy, the steady march of science and universal tendency to scholastic harmony all point to marked reform from drunkenness by the coöperation of ministry and medical profession, acting upon the principle of more humanity and less sickly sapping selfishness. Unique as it seems, time hitching physics and metaphysics together to cultivate the strong field of the drink habit, yet it is inevitable.

The popularization of the drink habit disease by the medical profession, can only be estimated in effect by the redemption and prophylaxis from drunkenness of armies of people. The movement signifies that we have reached a general intellectual consciousness, that can regard ordinarily the act of stimulant drinking as evidence of a known curable disease, also an intelligent idea of the medical use of stimulants. It at once throws up a barrier against drunkenness by destroying measurably the moral dualism in society regarding stimulant drinking, and by bringing the use of stimulants largely on a level with disease, as disease arrays forces within and without among all classes to fight out the disease of stimulant drinking.

The keynote is struck by the medical consciousness recognizing the expediency of attacking the diseased physical condition of the tippler that causes tippling. If the curative process was entirely psychical, and the medicine used was only an expediency for the more effectual treatment of the mind, nevertheless this course would be justified and in keeping with the great system of psychical treatment owing to positive results obtained. But since tippling is a symptom of a morbid physiological and curative condition without which tippling beyond satisfying curiosity as to the nature of stimulants, would not occur, there is no excuse for any physician not attacking medically the drink habit in the same professional spirit with equally positive diagnosis and prognosis, that he does a case of malarial fever, except for want of time or inclination. Exceptions must be made of physicians who have the alcoholic illusion. They are looking for things of elephantic proportion, and spiritualization in them is of the wrong kind and too fitful for utility in the management and treatment of stimulant drink cases.

Alcoholism is a curable nervous disease produced through tippling. Then why not prophylaxis? We quarantine against cholera, vaccinate to prevent

smallpox, check arthromita with mineral waters, use iodides and mercury against tertiary syphilis, teach dietetics and dress for healthfulness, to say nothing about the many mental symptoms both inherited and acquired, on account of which doctors so much worry to study up ingenious medico-psychic treatment because they are precursors of more serious disease. Then how about the keenly impressible youth or maid that have felt pain they know to have been caused by reaction of a poisonous dose of alcoholic stimulants? Will we wait in the presence of nature knowing the laws that foreshadow the inevitable until reason has been dethroned and a heart-broken family opens the door, for us to administer to a case of delirium tremens, or the door is swung open for the victim at the asylum meaning that a divine light has gone out under the eyes of the medical profession—the conservators of public health?

Others may conform to or reject the edicts of humanity in the new practice, but for myself I shall continue to treat the tippler as well as the inebriate in the humane sense of the healing art. The monomanism connected with this subject should be avoided. While any departure from the old way is likely to be regarded as unsound, we are protected in this practice by medical wisdom. There is no order of things to be broken into because disease is the enemy of life and it is the business of doctors to fight it when and wherever it is found. This subject should be well digested and assimilated to bring out the principle that lays at the root of the whole matter, and with a little practice the scope of conscientious action and the far reaching benefits of it to humanity will be apparent. There is no time for hairsplitting in vain effort to account for whisky drinking by the depressing effect of dark moons or cold spots on the sun, or by electrical polarization and similar nonsense when an army of people go to a drunkard's hell every year that could be saved by the judicious administration of medicines by doctors from a variety of twenty medicines.

Not all the cases that come under the care of the physician can be cured. Some of them like the ever present chronic dyspeptic or the hysterical woman of scarlet, will come and go without being permanently benefited. Reeking with disease incorrigible, hopeless as the lepers of old they will go down to the depths of depravity and serve to establish the science of prognosis in stimulant drink cases. As the drunkard under treatment begins to lose sight of the negative "whisky" environments and to bloom out in the opposite positive life environment, the physician has a psycho-physical problem before him that rightly understood, transcends in interest anything to be found in physics or metaphysics. Figuratively speaking it is pulling the smoked glasses worn for years from all the senses and issuing a new being into the full light of our real conscious existence. It is as passing from the dreary oozing fog marsh lying under the shadow of the mountain to its summit to look out upon the world with delight and wonder as one would released from bondage after years of persecution for a crime he believes he committed but of which he is proven innocent and publicly exonerated. Let us isolate and examine the principles of the subject of the drink habit that will serve substantially as our guide to the end of producing cures.

My Symptoms, Impressions and Experience During an Attack of Metastatic Rheumatism of the Duramater and Arachnoid Membranes of the Brain.

By James S. Whitmire, M. D., Metamora, Ill.

Mr. President and Gentlemen of the N. C. Illinois Medical Association: I have thought it probable that the history and treatment with my impressions, during a long siege of metastatic rheumatism of the duramater and arachnoid membranes which I experienced in my own case during the months of February, March, April and May of this year, 1892, might not be uninteresting to you. Hence I make no apology.

The fact that I am seventy-one years of age, and that I had been afflicted with acute, subacute and chronic rheumatism since June, 1889, so as to render me at times comparatively helpless, may be requisite for me to state for you to have a full understanding of my condition. I will state further, that a chronic condition of rheumatism had stuck by me ever since an acute attack which I had while in the army, during the months of June and July, 1862. But since that time I have never been so afflicted as to interfere with my business till June, 1889. At this time I had an acute attack which laid me up for several weeks, followed by a subacute and chronic condition that was general, affecting the bottoms of my feet, all the joints of my body, the muscles of the scapulæ, upper arms and those of the neck, so that if I wished to turn my head I had to turn my whole body in order to see in any direction, excepting straight ahead. During the months of December and January, 1891–2, on account of the prevalence of la grippe, I had a great deal of riding to do, and though I had a man to drive and help me in and out of my carriage, I was much exposed on account of the inclemency of the weather, though every precaution was taken in the matter of clothing and foot-wear to prevent being chilled. About the 18th of February I began to experience a dull heavy headache that continued day and night, which was something very unusual with me, though I was able to keep about and attend to office business. I now refused to ride, and turned most of my calls over to Dr. W. A. Mansfield, of our place. The first of March found me with pain in the head, still more severe than at first, which appeared to occupy the whole of both cerebral hemispheres, which now interfered with my rest and I could not sleep excepting on my back with my head elevated. I had never before, since my earliest recollection, been able to sleep on my back.

My case now began to assume a more serious aspect. I must either obtain relief or go to bed. I therefore began to investigate and look for the cause of this continued and intolerable headache. My temperature was 98° F. pulse 90°, and cardiac action feeble, urine scanty. On examination it showed acid reaction, and the presence of iodine which I had been taking for some time. My conclusion was that my suffering was caused from chronic rheumatism of the dura mater and arachnoid membranes of the brain. ℞. Black cohosh fld. ext. f℥i. P. D. & Co.'s elixir of strych., quin. and iron f℥i, potass. iod. gr. v. This to be taken in water every

*Read before the N. C. Illinois Medical Association, Dec. 6th, 1892.

four hours. To produce alkalinity of the blood, give force to the heart's action, and keep the bowels in a soluble condition: ℞. Sodi. phos. ʒiiss. germ. tinct. digital. gtt. iv. This dissolved in hot water and taken every six hours. This was followed faithfully, with occasional variations, to meet conditions that occurred till March 19th, when I surrendered to the inevitable, and went to bed. I found this to be a condition, and not a theory or myth that was confronting me; hence I did the next best thing after my own efforts had failed to give me relief. I was fearful that I would lose my intellectual faculties on account of the condition of the meninges of the brain, and therefore anxious to let my medical attendants know what I thought of my own condition, and the diagnosis I had made. Accordingly Dr. W. A. Mansfield and my brother, Dr. Z. H. Whitmire, both of Metamora, Illinois, were sent for, and asked to attend me during my illness. My consulting physicians did not disagree with me regarding the diagnosis. Pulse 100°, temperature 97½°, heart feeble, pain over the whole cerebrum most intense. ℞. Ergot fld. ext. fʒiii. fld. ext. blk. cohosh ʒiiss. gelsem., fld. ext. fʒi. hyosciam fld. ext. fʒi syrup to fill four ounce bottle. Dose: One teaspoonful in water every four hours. I was also ordered to take P. D. & Co.'s elixir of strych. fʒi., germ. tinct. digital. gtt. iv, fld. ext. cact. grand. gtt. ii, cit. potass. gr. xx, every six hours.

This prescription was intended, through the effects of ergot digitalis and strychnia, to lessen the caliber of the cerebral vessels, and increase the tonicity of the heart; and the gelsemium and hyoscyamus to lessen the intense pain of the head; the cit. potass. and phos. sodium to increase the renal secretion, produce alkalinity of the blood, and keep the bowels in a soluble condition. I was also directed to keep sacks of hot salt continually applied to my head, without which I could have had no rest or relief from suffering. This character of medication, with occasional variation, to meet temporary condition was rigidly adhered to till the first of April, and not a moment's rest was ever obtained, day or night, during the time unless my head was enveloped in hot salt; and it was kept so hot that I thought it must certainly roast my scalp. There was no regular time for sleep, but it was obtained at intervals, by day or night, as my condition permitted.

At this time I was in a worse condition than I had been at any time before. Temperature 97°, pulse 120, heart's action more feeble, my feet apparently burning up and tender to the touch, pain in the head intolerable, excepting when enveloped in the hot salt bath, and this only rendered the endurance of my torment possible. About this time, when the danger seemed most imminent, my three sons and their families arrived. I was glad to see them, but I was perplexed and could not imagine why they had come; for I had certainly not sent for them, and had not made up my mind to pass in my chips for some time to come. I said nothing, however, and about the time they left for home I was put upon P. D. & Co's fld. ext. manaca fʒi to be taken in water every four hours; also cit. potass. gr. xv, P. D. & Co.'s strych. quin. and iron fʒi, fld, ext. cactus grand. gii iv to be taken in water every six hours. This was followed with implicit punctuality till the 15th of April, when I was still more feeble and had not experienced the least relief from my suffering. Five week of conscious suffering without relief must have discouraged any other man; but I had faith in medicine, myself and my medical attendants, and I thought too, that a man with a usually good constitution, was too young to give up this life at seventy-one years of age without a struggle. This is the only world with which we are acquainted, or "know" anything positive about, and it matters not what any disgruntled remnant of humanity may say, this is the best and most beautiful world of which we have any knowledge, and I am so far in life, perfectly satisfied to remain among its lucious fruits and beautiful flowers.

Whatever I may have thought of my condition, my wife and daughter who tenderly cared for me alone through all this trying time, thought that I was worse, and sent, without my knowledge, for my son, Dr. J. W. Whitmire of Forrest, Ill., to visit me again. My physicians continued the fld. ext. manaca, also the former mixtures and added one pill of ext. ergot every six hours; besides this my son brought with him two bottles of effervescing cit. of lithia which I was directed to take at any time when I wished a drink. I found it very agreeable and took it as often as four or five times a day, for two or three days before I recognized any result, but at the end of that time I told my daughter to write to Dr. J. W. W. of Forrest, that the lithia had broke up the fountains of the kidneys, overflowed the bladder and deluged the chamber. Four or five days previous to this, I had begun to have some mitigation of suffering at short intervals; but when my kidneys began to act so freely under the influence of the lithia, the pain in my head slowly and gradually subsided, so that on the first of May I was on the highway of recovery; but I had to keep up the hot applications at night in order to procure sleep till after the middle of May, besides I kept up the use of manaca, elixir of strych. and all the last prescription till the pain in my head had entirely ceased to disturb my rest.

At no time from the beginning till the end of my sickness did my temperature come up to 98.5°, but varied between 97 and 98° F. On this account, about the last week in April when recovery commenced I was allowed fʒii of London porter three times a day, which was continued till the first of June. My diet during the whole time was Mosqura's beef meal suspended in a hot solution of Horlick's malted milk, and occasionally a soft egg. Though I had been many times almost helpless within the last three years, and suffered much pain from rheumatism, when it extended its field of operation to the dura and arachnoid membranes of the brain, the climax of the most intense suffering was reached. Nor did this attack subside without leaving its indelible footprints in the organs and their membranes; because there was thickening of the dura from interstitial fibrous deposits about the right optic nerve as it emerges from the optic foramen, so as to compress it sufficiently to completely destroy the sight of the right eye; the left also being somewhat affected; and my hearing in both ears blunted, the left being more affected than the right. To relieve this pressure by absorbtion I continued the elixir of strychnine, etc., etc., and added P. D. & Co.'s hydriodic acid, double strength for two months or more. My left eye is somewhat improved, but my hearing has not been benefited. Another footprint was left, in the complete obliteration of both external temporal arteries from the zygomatic arches to their terminal branches.

This sclerotic condition may be the result of the disease or the constant application of the hot salt, probably the latter, the lumen of the vessels being completely closed so that blood no longer circulates through them, and they becoming slowly atrophied and absorbed, though they may still be felt like lifeless and attenuated cords; the scalp, however, seems sufficiently nourished by the occipital arteries, and the superciliary arteries that make their exit from the cranium at the orbital notch and other sources of the collateral circulation.

But, notwithstanding all my sufferings, and the indelible tracks left in the organs and tissues on account of disease, there still remains some pleasant memories connected with the terrible ordeal through which I passed. These are the delightfully pleasant and beautiful illusions that appeared to my mental vision when my disease seemed inevitably lethal, which was for a few days between the 1st and 15th of April; and I would not, even at this time lose their pleasurable expression for any reasonable consideration; and I really felt that I was lost and abandoned when they ceased to appear. They came unbidden in my waking hours, at any time when I would close my eyes, and I did not mention them to my family or physicians, lest they would think I had lost my reason and cease paying attention to my real complaints; but for all that, I really reveled with extatic delight in their ephemeral beauty. At one time the illusion would be a beautiful woman standing to the front of a picturesque landscape, smiling and beckoning me to come; at another I would see all the animal kingdom, by twos, of different families passing in panoramic view before me; and, again, I would see a battalion of Sheridan's cavalry mounted on splendid horses beautifully comparisoned, on a scouting expedition. These, with other scenes ocurred that I need not mention, as these will suffice to give you a proper appreciation of what I know to be illusions, but seemed indeed real at the time.

Gentlemen, I have written this more fully that you may, under like conditions, appreciate the condition of any patient that may come under your supervision or care.

Breach of promise suits can be successfully defended in Kentucky and North Carolina on the plea of syphilis.

Prof. Keen says that in some few cases the bacteria of erysipelas injected in a cancerous tumor have at first produced erysipelas in the patient, but later on have effected a cure of the tumor.

A NEW SUBSTITUTE FOR COCAINE.—The acetanide of eugenol, from the oil of cloves, a recent preparation is said to possess local anæsthetic properties. It produces no caustic effects, is highly antiseptic, and therefore superior to cocaine for minor operations of the mucous membrane.

Dr. Ralph Butterfield of Kansas City, a graduate of Dartmouth College in 1839, has bequeathed $180,000 to the college for the purpose of founding a professorship in archeology and kindred subjects, and for the erection of a suitable building. The donor acquired his property in business, and not by the practice of medicine, and was supposed to be poor and needy until his death.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Dennis on the Achievements of Modern Surgery.

This editorial from the *American Lancet* is a most satisfactory reply to those Americans who continually bewail the inferiority of native physicians:

In a recent address (*Medical Record*) Dr. Frederic S. Dennis traced the advance of American surgery in its influence upon other nations. He shows that American surgery eclipses that of all other nations of the world in regard to original research, in the introduction of new methods of treatment, in the perfection of older methods, in the inauguration of a complete ambulance system, and in tangible results.

He ascribes the rise of American surgery to the dissemination of her medical literature, the formation of medical libraries, the organization of hospitals and laboratories, and the foundation of medical schools. It seems to us that factors of importance are omitted, viz., the influence of medical societies, the development of medical journals, and the sudden needs of doctors brought face to face with new problems and far from any possibility of aid.

After stating the surgical work of Americans, he says that our surgeons eagerly seized upon all the good of other nations and utilized all principles, theories, discoveries, inventions, and knowledge, while all other nations refused to learn from each other. With the adaptability and susceptibility of a plastic state, the American surgeon has utilized every aid for working out the very best results in surgery.

American surgery is now studied by all nations, and if it were blotted out there would be little left of surgical progress during this century.

Among the explanations for this wonderful surgical progress, he directs attention to the innate courage of our Puritan ancestry. That same bravery which spurred the Puritans to cross the great unknown ocean and to settle in the primeval forests for the sake of exercising individual liberty, stirred them to great efforts in behalf of surgery, making them fearless and bold. Their self-reliance and manly independence were necessary to win success in surgery, without which America would never have attained its present high place in the mind of the civilized world.

Dr. Dennis' paper will stir the heart of every lover of surgery. Especially must every American feel his pulses quicken, and a resolve take possession of him to do what he can to add to this long list of surgical achievements. Americans believe in their country, and American doctors in the profession of their land, but the article before us gives both a firmer basis for their faith.

'Tis a fact that American surgery has led the world and still leads it. To our teachers must come, in the not distant future, the *savants* of other nations, to learn the newest phases of surgical art.

An Able Reply to Lay Editorial Assininity.

The following clipping from the Chicago Herald, explains itself. It is a creditable rebuke to the offensive presumption of certain newspaper ignoramuses We wish that we could present the name of the able writer.

CERTAINTIES OF MEDICAL SCIENCE.

CHICAGO, Feb. 2.—*Editor of the Herald*: Your editorial of to-day entitled "Uncertainties of Medical Science" bears upon its face the evidences of an attempt to be fair, characteristic feature, by the way, of THE HERALD. Nevertheless, it shoots wide of the mark in several particulars.

1. "Medicine is almost as far remote from an exact science as alchemy was in ancient times," etc. This is not the judgment of those whose intimate knowledge of the subject qualifies them to form a judgment.

2. It is unsafe to assume that the physician's reticence regarding a patient is induced by his ignorance of the condition present. Physicians are not reticent among themselves as regards conditions, but always as regards personalities. The standpoints of the physician and the journalist as to what shall be held sacred are so different that it is quite improbable that they will ever agree, and it would be useless to discuss the matter here.

3. "During the progress of these mystifying methods a variety of diseases was named," etc. This variety of conditions which is so puzzling to the editor is perfectly clear to the medical man. Such descriptions convey definite and certain pictures to him because he is acquainted with the correlation of these several conditions.

4. "The opinions of physicians as to causes of disease or death in their patients ought to be written in language easily understood by common readers of the newspapers." This implies that there are exact equivalents in ordinary language for technical terms, which is not the case. Nor is it possible to elaborate so as to make plain. Attempts to popularize science or to make short cuts to the understanding of scientific terms and conditions which have acquired very definite meanings and great wealth of correlative significance through long years of study are puerile and always miss the mark. To really develop for the layman an accurate understanding of what little the doctors know regarding the case of the late Mr. Blaine would require the entire space of several issues of THE SUNDAY HERALD.

5. "There is no man so dear to the hearts as he who attends to his professional capacity at the bed of the sick," etc. We would not for a moment detract from the dignity and nobility of the part which, as a humanitarian, it is often the privilege of the physician to play, but he stands in some danger of being overwhelmed at times by a sentimentality of fungus growth. The great mass of the people with whom the physician comes in contact he meets under abnormal conditions. It is not strange, therefore, that he is erroneously judged. Judgments warped by the passions are notoriously incorrect. It is, therefore, best known to the physician that he is often credited with miracles where he has done nothing and condemned for neglect where his labors have been great and results real. The resultant of these false ideas is still to the physician's disadvantage. He would be exceedingly fortunate if always estimated truly.

6. "Exact knowledge in medicine." No other learned profession has made such great advancement, either actually or relatively, as has medicine in the past century, and particularly in the past decade. The enormous amount of positive knowledge added to medicine in the past few years has necessitated a complete change in the means and methods of medical education. And still there remains a great unexplored field. At the bedside the physician of to-day meets the same problems, emergencies and difficulties as were met by the physicians of a century ago, but his wider knowledge has simplified many of these problems and cleared away many of the difficulties, so that he acts with greater precision and success. He faces the same problems to-day which the physician a century hence will face. But he lacks much of knowledge which this later one will know He works in the dark where the later physician will have light. The physician of to-day does not claim to know all that may hereafter be known of medicine, although it would often seem that the layman would charge him with the necessity for such wholesale knowledge. Aside from the acknowledged deficiencies of medicial science it is a fact that the profession is to-day in possession of an amount of knowledge, scientific and empirical, of working value, which, in the hands of those qualified by training and judgment to properly use it, is capable of accomplishing vast results.

7. The medical profession is to-day expending herculean efforts to extend the range of accurate medical knowledge. It is practically unaided by the community. It is often handicapped by it. Its real accomplishments are not understood nor appreciated. Its honest efforts are regarded with suspicion.

MEDICUS.

Doctors and the Daily Papers.

One of the leading city papers, taking as a text the reticence of the physicians who attended Mr. Blaine, reads the medical profession a long lecture on its ignorance. It demands that doctors should express themselves in simple, direct English instead of resorting to technical terms. It manifests its joy over a bill now pending in the State legislature which requires doctors to write their prescriptions in English.

It is supposed that every man knows his own business best, but the practice of medicine is the exception to this rule. Few men there are, and fewer women, who do not regard themselves as competent to pick flaws in the treatment of every case attended by a physician. Who has met a man who could refrain from prescribing for a cold? He may live in Japan, where Sir Edwin Arnold says colds are practically unknown, but he is yet to be discovered in America. Because a physician declines to betray professional secrets and disregard the wishes of his patient and his family, his disinclination to talk to furnish a newspaper with news is set down to ignorance. Because he of necessity resorts to technical terms to describe

conditions for which there are no equivalents in simple direct English, he is hiding his ignorance behind big sounding words, and posing as a monument of learning and skill. What profession is there which has not its technicalities, invaluable to it, but Greek to outsiders? If this criticism is valid the printer should forsake his "pi," handle his "shooting-stick" no more, forswear "quoins" and "lock up forms" forever.

As to writing prescriptions in English, that is easily enough done, but it will make it hard for the druggist who finds on his shelves two or more drugs with the same common name, and harder for the patient, who may or may not get what is intended for him. Medicine is more nearly international than any other science, and the difficulties caused by writing prescriptions in the language of the country instead of in Latin is best understood by those who read the French journals and find it impossible to learn the drug which a learned writer describes by its common name. The common names of drugs differ in different localities. In New England "Unguentum" or "Anguentum" is the common name of mercurial ointment. What South-westener will fail to recognize nux-vomica in the "ox-vomit" called for by the man whose chickens are being carried off by hawks? If the legislature will give the profession a weapon to wield against quacks, make the requirements for permission to practice severe, and enforce them thoroughly, it will do more to protect the public health than by attempting to regulate technical terms whether used in prescriptions or not.

National Quarantine.

The medical profession of Chicago, or a large part of it, has assembled and passed resolutions in favor of a national quarantine as opposed to the present form operated under State law. Notice is given that the State law of New York was found inoperative during the cholera scare of last summer. The New York *Medical Record* and *Medical Journal* hold a different opinion on this subject. They give great credit to Dr. Jenkins and the other State officials who kept the pestilence from getting a foothold. In the event of a national quarantine law being enacted, Dr. John B. Hamilton would probably be made the chief executive officer. Dr. John B. Hamilton is a Chicagoan. We are all his friends, hence, these resolutions and the inefficient quarantine regulations of New York. 'Rah for Chicago.

A Correction.

Dr. Shimonek's article, The Treatment of Typhoid Fever, which appeared in the January number of this journal, on page 8, line 21, should read 40 grains instead of 4.

Dr. Bartholow.

The welcome news comes from Philadelphia that Dr. Roberts Bartholow has been entirely restored to mental health and will again take his place in the ranks of the profession he so long adorned.

Abstracts.

Surgery.

Prostatitis from the Bicycle.—Dr. J. W. Irwin reported to the Louisville Clinical Society that within the last eighteen months five cases of prostatitis had come to his notice, which could be traced directly to the pressure on the prostate gland by the saddle of the bicycle. Four of the subjects have passed the years of middle life, and one is in his teens. In all cases the phenomena presented by them were very similar in character. After riding the bicycle for a few hours, during the act of micturition a feeling as though the vesicle end of the urethra was raw, was experienced; then a full feeling behind the scrotum came on, which was unattended by pain. Inordinate and persistent erections of the penis, coming on at short intervals and lasting three or four days, was the most unpleasant feature observed. The urethra during the act of micturition felt raw and tender under pressure; weight and some dull pain was felt in the testicles. There was no discharge from the penis at first, and after two or three days a little moisture was observed coming from the meatus urinarius. The discharge seemed to be very thin and colorless. The desire to void the urine more frequently than normal was present while the trouble lasted. The treatment advised was saline laxatives, and the free use of water internally. For the relief of troublesome erections, camphor mono-bromide in large doses was advised. This course of treatment, together with the removal of the cause, gave relief in from five to seven days.—*Med Standard.*

Vermiform Appendix Containing a Foreign Body Found in a Hernia.—H. Schmidt (*Münch Med. Wochen., 1892*). The vermiform appendix is rarely found within a hernia, but a few cases having ever been recorded in medical literature. The author reports one case. A woman aged 53, who had a right inguinal hernia of recent origin, which became inflamed, and after a few weeks opened and discharged blood, pus, and fæcal matter. During the operation Schmidt found a hernia sac in which was caught a vermiform appendix—along the side of this a sound could be readily passed into the abdominal cavity.

The hernial sac was removed and its opening closed. Complete recovery. Close examination of the removed vermiform appendix disclosed the presence of a large black pin.—*Medical and Surgical Reporter.*

Treatment of Syphilitic Ulcers.—V. T. Svertchkoff (*Vratch*, No. 38, 1892), finds that inveterate or obstinate syphilitic ulcers of any kind are best treated as follows: The lesion should be thoroughly cleansed with a two per cent solution of hydrogen peroxide, then dried with absorbent cotton wool, and covered with a piece of wool soaked in a one to two mixture of carbolic acid and camphor. The dressing should be changed two or three times a day. In from three to five days the ulcer becomes cleaner and studded all over with abundant succulent granulations. After this it should be dressed twice daily, either with a one to four mixture of aristol and vaseline oil, or with a mixture of dermatol and vaseline in equal parts, the layer being covered with a piece of mercurial plaster twice as large as the ulcer. Rapid cicatrization ensues, the lesion healing soundly according to its

size, in from fifteen to forty days from the commencement of the treatment. The author mentions that in his hands the campho-phenol mixture alone proved of great service in cases of simple ulcers, suppurating wounds, soft chancres, and chancroid buboes.—*British Medical Journal.*

CATHETERIZATION OF WOMEN.—Dr. Paul F. Mundé said recently in a lecture (*Int. Jour. of Surg.*): In order to avoid carrying anything into the bladder which may give rise to infection, such as pus, vaginal secretion, blood, or anything that does not belong there, I always have the lips of the vulva separated, the vestibule cleaned with bichloride solution, and then carefully exposing the urethra I introduce a glass catheter. The catheter should be always kept in a mild carbolic acid solution. I have had two cases of acute cystitis brought on this winter in my private hospital through carelessness on the part of a nurse in the use of the catheter. Both patients had been operated upon by myself without the occurrence of any trouble from the operation. So I would advise you to be very careful with the use of the catheter in this respect.

A PHYSIOLOGICAL STYPTIC.—According to the London correspondent of the *Therapeutic Gazette*, Dr. A. E. Wright's new styptic is the outcome of considerations on the factors which determine coagulation. It occurred to him that the best way of controlling hæmorrhage would be to imitate as closely as possible one of nature's own methods and produce natural coagulation in the blood. Now the addition of fibrin ferment to the blood is in itself sufficient to hasten its coagulation. We know, besides, that the coagulabil ity of blood is dependent on the proportion of lime salts contained in it, blood absolutely deprived of these being uncoagulable. Combining these two ideas, Dr. Wright has prepared his styptic, which is a solution of fibrin ferment, together with one per cent of calcium chloride. The efficiency of this solution, when applied to severe wounds in animals, is, as the writer has himself seen, very remarkable; a small quantity applied with a swab of cotton-wool being almost immediately sufficient to arrest the hæmorrhage, which is ordinarily very profuse. The solution is prepared as follows: the blood of cattle or sheep is received direct into about three times its volume of water, is set aside to gelatinize for a few moments, and then thoroughly whipped with twigs. The fibrin thus obtained is gently washed, so as to free it from blood pigment, and then extracted for about twenty-four hours with five to ten volumes of water. To the filtered extract is then added one per cent of calcium chloride. The great advantage, besides its efficiency, is that the process of occlusion by a natural coagulum is one which is calculated to do least harm to surrounding tissues. The action of the styptic is perfectly selective, being exerted on nothing but the blood with which it is brought in contact. No other styptic so thoroughly fulfills this condition.—*N. Y. Med. Times.*

AN EASY METHOD OF REDUCING DISLOCATION OF THE HIP.—Bird (*Australian Medical Journal*, vol. xii., No. 4) states that ordinary dislocations of the femur are not always easily reduced, even when seen soon after the accident. In difficult cases he has adopted the following procedure with success. If the left be the injured side, the patient's left lower extremity is placed over the surgeon's right shoulder, so that the under surface of the bent knee is closely applied to the shoulder, and the leg hangs down the surgeon's back. The foot is then hooked under the front of the surgeon's left elbow. Great leverage can now be exerted on the head of the bone, the patient's pelvis being steadied by an assistant. The surgeon, raising his body, lifts the patient's whole lower extremity, with, if necessary, the expenditure of considerable power, so that the head of the bone is lifted out of the nidus in which it is resting. This leaves the right hand of the operator free to help the now easily moved head of the bone into the socket.

Bird found this plan very useful in a case in which the head of the femur had slipped into the sciatic notch. In this case there was hardly any shortening, and much more than the usual amount of movement. The ordinary methods of reduction failed, probably because enough power could not be brought to bear on the head of the bone to unhook it from the sciatic notch. In cases of dislocation on the dorsum, this method is also useful, but it is desirable in such cases to place a hard pillow under the patient's buttocks, in order to make the traction in the right direction.—*Therapeutic Gazette.*

REMOVAL OF INGROWING TOENAIL.—Dr. John A. Wyeth, *Int. Jour. of Surgery*, describes this operation as follows:

The foot and toes are first cleansed and thoroughly disinfected. An elastic ligature is thrown around the toe as close to the metatarsal junction as possible. A hypodermic needle is introduced under the skin on the dorsum of the toe and just about the posterior border of the matrix. Three or four minims of a four per cent solution of cocaine are injected at this point, and the needle pushed under the skin to the right and left, until from fifteen to twenty minims have been injected across the toe and on either side of the nail. The line of injection is in the form of a horseshoe. This procedure is to be kept up until the anæsthesia is complete at all points around the nail, forty minims of a four per cent solution being generally employed. In from three to five minutes anæsthesia is complete.

An incision is made from the middle of the posterior margin of the nail directly backward for half an inch. Then follows a second incision across the toe, extending as low down as the most inferior portion of the nail on either side, uniting with the perpendicular cut and giving to the entire wound the shape of a T. The two quadrangular flaps are now dissected up, turned one to the right and one to the left side, and held apart by means of retractors. The nail is next split from before backward in the median line, the incision extending through the matrix as far back as the transverse incision through the skin. Both halves of the nail and the matrix are removed, all granulation tissue scraped away, and the foot dipped into a basin of warm sublimate solution of the strength of 1-2000. The elastic tourniquet is removed and the wound allowed to bleed for a short time. The excess of cocaine is in this way washed out of the tissues when the ligature is again applied.

The flaps are now brought into apposition, the space formerly occupied by the nail packed with sublimate gauze, and the entire toe enveloped in the same dressing. A narrow bandage is applied around

the toe, so as to keep the gauze in place and to prevent bleeding by compression. A large piece of protective is laid over this and a second bandage applied. When the elastic ligature is reached it should be taken off and the roller bandage carried up the foot.

A single such dressing usually suffices and should not be removed for ten days or two weeks.

A More Effective Method of Removing Superfluous Hairs than by Electrolysis.—The following editorial in the Omaha *Clinic* contains information of value:

Take two of the smallest sized jeweler's broaches, the shafts of which are finer than the finest cambric needle; one is introduced directly along the shaft of the hair into the bulb, the other on the opposite side of the first so that the two needles shall come in apposition along their ends and in the hair bulb.

The needle holder of the second needle should have a switch button on it so that when contact is made and a current strong enough is passed, renders the contact points of the needles of a low red heat *for an instant only*. To do this well it is necessary to have a battery which is constant at all times, such as a current controller from a fifty volt alternating street incandescent light circuit, regulated to about three volts and allowing of from five to seven amperes passing through the needles; in this way the hair becomes readily extractable, there is no danger of scarring or pitting of skin and the pain slight compared to electrolysis.

The greatest nicety of precision must be exercised in these details, otherwise there will surely be an unsightly cicatrix or pit.

The Present Position of Antiseptic Surgery.—From time to time it is not only interesting, but is also a necessity to take an occasional retrospective glance through the near past, and, as it were, compare notes and see where we stand.

Just now, that sufficient time has elapsed, we may inquire: What is the precise, definite position of antiseptic surgery? The medical side of the question we will give our attention to later.

We believe, from what can be gathered from the latest literature on the subject, that antiseptic surgery, as taught and practiced as recently as five years ago, is now something of the past.

When Lister introduced the spray, and argued with great force the importance of purifying the atmosphere of the operating room, and seeking out the stray germs, lodged in sundry recesses of one's apparel or surroundings, Lawson Tait, with stinging sarcasm, recommended that the nozzle of the apparatus would do the most good when pointed out through the window. The spray went.

Reports commenced to come in that antiseptics must be eschewed in the surgery of the peritoneum. It was discovered that traumatisms penetrating the skull and involving the brain, when treated antiseptically, were attended with a terrible mortality, through a consecutive, irritative meningitis. Antiseptic irrigatiou of the pleura, in empyema, is no longer employed by French surgeons.

Bichloride solutions, when used in amputation, though they favor prompt union, are said to cause, very often, painful, useless stumps, through an insidious osteo-myelitis which they excite in the cellular elements of the cancellus bone substance.

Antiseptics—or, rather, chemical solutions, were practically condemned by the American Surgical Convention of 1891. Prof. Chiene, a townsman of Lister, sounded the death-knell of antiseptics in Great Britain, when he announced and demonstrated that chemical solutions of any description were foreign substances, irritants, and had no place in healthy tissues.

This, indeed, is a sad commentary on what was taught but yesterday, as a cardinal doctrine.

Morell Mackenzie narrowly escaped imprisonment at the hands of his unfriendly German confreres, because he did not boil or pickle his spatula, every time he used it on the Prince's tongue.

Although the above must be a humiliation to those who pin their faith absolutely to scientific medicine, it will teach a useful lesson to many, who are too strongly inclined to dogmatize.—*Times and Gazette.*

Flaming Surgical Wounds.—M. Felizet gave an interesting account of the treatment of several cases of surgical wounds by the flame of the blowpipe. He said that in many surgical lesions, the tuberculous affections in particular, it was often difficult to draw a positive line between the healthy and the diseased tissue consequently it is necessary to complete the operation of the knife, the chisel or the currette by the application of certain caustic solutions, such as chloride of zinc, etc. After the most complete resection their remains always enough of tuberculous matter to infect quite a series of animals when injected. The method he has employed in a great number of cases had for aim to destroy the diseased parts and to provoke a reaction which produces a zone of protection against the invasion of infectious matter. The principal of this method consists in passing rapidly over the wound the flame of a blowpipe of which the temperature attains 27-32 degrees F. He obtained by this treatment thirty-eight cures with suppuration, fourteen resections of the knee, eight of the hip, five cold abcesses of the same joint, one enormous abscess of the breast, one adenitis, etc. The lips of the wound are protected by several compresses steeped in an antiseptic solution, and the flame of a blowpipe is passed rapidly over all the raw surface. The reactoin is insignificant, and the lips of the wound, which are always left untouched, and are brought together over a seared and consequently dried surface. M. Nelaton said that in two cases of cancer he was able to retard a relapse by the use of the gas cautery.—*Medical Press.*

A New Treatment of Hæmorrhoids.—A Holland physician, Dr. Aghina, treats this complaint in the following manner: Fix at the extremity of a female sound a condom, and at the other end a rubber bulb furnished with a stop-cock. After carefully cleaning the rectum by washing and a purgative of citrate of magnesia, let the patient recline on a bed for some hours. Then introduce the catheter, covered by the condom, into the rectum, in such a manner that it penetrates above the internal sphincter, then the membranous bag is inflated with air and the stop-cock closed. The dilated veins are compressed by the distended bag, and they soon, according to M. Aghina, take their normal volume, provided the compression is maintained for a sufficiently long time. This operation should be repeated after each defecation, and the patient should rest in bed for fifteen

days at least. The author has obtained excellent results by this proceeding, and he does not hesitate to discountenance, in the treatment of hæmorrhoids, all surgical intervention which is not justified by the urgency of the case.—*Med. Abstract.*

A Simple Method of Promoting the Healing of Wounds in Bones.—Emil Senger, in the *Centralblatt für Chirurgie*, describes his method of treating wounds of the bones in which the periosteum has been lost. It is as follows. The wound is to be treated antiseptically with moist dressings for a few days; then with a chisel the external table, or at least a part of it, is to be chiseled off so as to expose the blood vessels beneath. A moist dressing being again applied, in a few days granulations begin to sprout up, and in a few more will have spread all over the exposed area. Naturally this procedure is not to be attempted in progressive phlegmonous troubles.—*Epitome.*

Lawson Tait on the Treatment of Peritonitis. —Years ago I was driven to the determination to discontinue the use of opium by the mouth after abdominal operations, for two reasons; first, its action on the intestines is most certainly to modify and even suspend vermicular movements; and secondly, it masks the real condition of the patient. One dose of morphine, given under the skin immediately after the operation, is all that my patients ever get, and the bulk of them do not get that.

Regarding the intolerable thirst that follows the opening of the peritoneal cavity, I have come to look upon it not as an indication for the administration of fluids, but rather for withholding them. Ice is one of the things that should be banished absolutely from the sick room. It never acts in any other way than to increase thirst.

Again, if nausea sets in on the third or fourth day, or at any time after, all food (and in that I include water) is absolutely stopped for twelve hours or even longer if necessary. I was driven to this by the uniform experience that all drugs employed for the arrest of vomiting were absolutely futile; that any food given came back only altered by biliary admixture. Further, I was influenced by the perfect certainty that nothing could possibly be digested or absorbed by the stomach so long as bile was being poured into it.

I have therefore a belief that the starvation and withholding of fluid prevents the mechanical stasis of the circulation in the intestinal coats, which appears to me to be the initial stage of the fatal process of peritonitis, and this preventive measure I endeavor to assist by stimulating the peristaltic movement. I have tried a vast number of different kinds of enemata—some suggested by own thought and others suggested by ingenious friends—but I have always gone back to soap and turpentine. It is the business of any nurse watching one of my abdominal sections to note every six hours a set of four conditions—the pulse, the temperature, the occurrence of distension, and the passage of flatus *per anum*. So soon as the latter is freely and naturally established our anxiety ends, though our watchfulness is unremitting. The want of such passage for twenty-four hours after an operation, especially if accompanied by the slightest suspicion of distension, is dealt with without fail by the nurse herself, on her own responsibility, by the administration of a turpentine enema. If the turpentine does not answer the nurse reports, and a mild saline purgative is ordered—generally a seidlitz powder—and this is repeated every four hours until it acts. If the distension increases we never rest until we have had the bowels moved, and then our anxiety is nearly always at an end and our efforts rewarded by recovery. But above all things there must be no time lost, and nobody who may be called into consultation by anxious friends must be permitted to write a prescription and try some favorite mixture.

When called into a case of well-established peritonitis I always urge a trial of this treatment, because the stage may not have passed at which it may still be effective, but the chances are that it has. I have never said that the purgative treatment will cure peritonitis, for peritonitis, once it is completely established, is a practically incurable disease, and almost uniformly fatal. Of this I am certain, if you subject the patients (not the peritonitis) to the purgative treatment, the number who will go on to incurable peritonitis will be fractional compared to what will be the result if they are left alone or submitted to any other treatment.

The practical outcome of my empirical experience is this, that the purgative treatment of peritonitis or threatening peritonitis, if it be promptly brought to bear on the case, will gain the all-important time, which will eventually turn the scale in the favor of the patient.—*British Medical Journal.*

A New Method of Making an Artificial Anus.—Chaput (*Archiv General de Medicin,*) describes a new operative procedure devised by himself for the establishment of an artificial anus. The parts in the left inguinal region are rendered anæsthetic by means of cocaine, and an incision is made parallel to Poupart's ligament, and opposite the anterior superior iliac spine. The abdominal wall is to be cut through and the intestine brought into the wound. The intestine is then fixed on each side of the wound by means of pressure forceps. Each pair of forceps is so fixed as to hold in opposition the intestinal wall, peritoneum, and the muscles in the lateral margin of the wound. Eight pairs of forceps are used; these are left on for twenty-four hours and then removed. The parts are washed with chloride of zinc solution, and covered with an antiseptic pad fixed with a bandage.

The same operation may be carried out after resection of the gut for tumors or for intestinal gangrene. Four cases have been operated upon by the author, three of them with good results. One died from the effects of intestinal obstruction.—*Univ. Med. Mag.*

Gunshot Wounds in the Abdomen.—There are four cardinal points in the management of the abdomen, viz.:

1. Have everything in readiness, the patient thoroughly prepared, the abdomen thoroughly cleansed, and the surrounding surfaces covered with antiseptic cloths before an anæsthetic is administered. I have seen patients kept under an anæsthetic for ten or fifteen minutes while the operator and assistant were getting things ready. This materially lessens the chances for recovery, for it is well known that the shorter the period of anæsthesia, the less the shock, etc.

2. After the abdomen shall have been opened the

first business in hand should be to find the source of the hæmorrhage, if any, and check the same. I speak from sad experience on this point, for I believe I lost a patient from lack of observance of this rule. While sewing up gunshot holes in the small intestines, which were not bleeding, and the closing of which could just as well have been delayed, a fatal hæmorrhage was going on at another point.

3. As far as possible the intestines should be kept in the peritoneal cavity. I know, however, that this cannot always be done. All know that useless handling of the gut, and the dragging upon its mesentery, as well as the exposure to cold, etc., add greatly to the shock.

4. To finish the operation at as early a moment as possible, consistent with the proper management of the same.

It is impossible to lay down hard and fast rules for the government of the surgeon in his dealings with these cases, as the difficulties of each must be surmounted as they arise.—*Dr. H. C. Dalton in Annals of Surgery.*

Skin Grafting upon the Cranium.—Dr. F. C. Schæfer, Journal A. M. A., reports an unusual case of skin grafting and from his experience makes the following deductions:

1. When grafts are set within five mm. of each other, a stronger skin is produced than when they are placed further apart.

2. A graft will grow to many times its dimensions, so that a circular graft three mm. in diameter will form a piece of skin eighteen mm. wide, but the skin will not be as strong or of as good a quality as when the grafts are closer together.

3. *Dermal* grafts with a few fibers of connective tissue form a smooth, soft, pliable, movable skin, presenting the characteristics of normal integument.

4. Epidermis placed on the cranium produces only a thin film, which ulcerates readily.

5. Auto-dermal grafts are more liable than heterodermal grafts, providing the subject is healthy.

6. Grafts from a person near the patient's own age do better than from one much older or younger.

7. With *dermal* grafts the follicles are preserved, whereby the patient is made more comfortable, the skin produced is more natural, hence more durable.

8. The most reliable skin is formed by grafting about the circumference of the wound, say one or two rows, producing a narrow strip one cm. wide, and waiting until the blood vessels are well developed in it, then plant another series close to the last ones. By this plan, contraction in the marginal tissues takes place in advance of the subsequent graftings, diminishing the liability for the ulcerative process to occur by reason of such contraction.

9. The new skin is fed by the tissue upon which it rests, probably by osmosis, but depends for its permanent sustenance upon the vessels growing into it from the circumferential tissue. This fact is thoroughly established in my mind, as it was frequently demonstrated by the death of the patches of new skin removed from the marginal tissue. Time and material can therefore be saved by constantly grafting from the circumference in large wounds.

10. All things considered, grafts will grow better in a new wound than in an old one; and the more recent the wound the more certain are they to thrive. In the present case, during the last three months, notwithstanding the improved physical condition of the patient, only twenty per cent of the auto dermal grafts took, while six months ago eighty-five per cent could be depended upon.

Medicine.

Certain Peculiarities in the Urine of Malarial Subjects.—Baccelli and Pensuti, Fifth Congress of the Italian Society of Medicine.—*La Semaine Medicale.*

The conclusions to which their researches on the toxicity of urine among patients affected with malaria, and on the causes of that toxicity have drawn the authors are briefly as follows:

First, the toxicity of the urine varies greatly with the individual, the gravity and duration of the malady.

Second, it increases from the onset of the affection up to the period of convalescence.

Third, in general, it is greater during the apyrexia than during the exacerbation of the fever.

Fourth, from time to time, this toxicity may increase rapidy and considerably without appreciable cause and in the absence of any aggravation of the disease.

Fifth, the urinary toxicity is in proportion to the elimination of potassium by the urine; but this proportion is not fixed, a fact which leads to the deduction that the toxicity is due, in part at least, to other chemical products, phosphorus for example.

Sixth, the toxicity is also in proportion to the coloration of the urine. It diminishes by half when the urine has been discolorized.

Baccelli announced that he had succeeded in producing by inoculations on a healthy man, a typical quartan and a double, tertian malarial fever. The period of incubation was twelve days for the former and six days for the latter.—*Jour. Cut. & Gen. Urin. Diseases.*

How to Treat Those Who Are Overcome with Gas.—1. Take the man at once into the fresh air. *Don't* crowd around him.

2. Keep him on his back. *Don't* raise his head or turn him on his side.

3. Loosen the clothing at his neck and waist.

4. Give a little brandy and water—not more than four tablespoonfuls of brandy in all. Give the ammonia mixture (one part aromatic mixture to sixteen parts of water) in small quantities at short intervals—a teaspoonful every two or three minutes.

5. Slap the face and chest with the wet end of a towel.

6. Apply warmth and friction if the body or limbs are cold.

7. If the breathing is feeble or irregular, artificial respiration should be used, and kept up until there is no doubt that it can no longer be of use.

8. Administer oxygen.

Responsibility in the Early Stages of General Paralysis.—After carefully studying this subject, Dr. Frank P. Norbury, *Medical and Surgical Reporter*, arrives at the following conclusions:

I. General paralysis is a plea for irresponsibility.

II. No judge is warranted in committing a general paralytic to the penitentiary.

III. It is not judicious or right to commit general paralytics to insane hospitals on a *mittimus*.

IV. When in doubt as to the existence of general paralysis, it is the duty of the judge or jury to forego sentence and commit the individual to an insane hospital for observation, at least long enough to determine the existence or nonexistence of general paralysis.

A New Dietetic Regimen.—M. Germaine See, of Paris, one of the mosteminent of French physicians, has recently called attention to the fact that modern investigations have considerably changed the views of physiologists respecting the proportion of nitrogenous and carbonaceous food elements required for the sustenance of the body. The old theory required 4 ounces of albumen, 1⅓ ounces of fat, and 12 to 15 ounces of carbohydrates, for sugar and starch, making in all, 17 to 30 ounces of water free food. According to M. Germaine See, "these figures are to-day completely changed, as the result of observation upon different races and physiological experiments; the amount of albumen required has been reduced one-half." The proportion now recognized as necessary for the maintenance of health is: Albumen, 2 to 2⅓ oz.; fat, 2 oz.; starch and sugar, 16½ oz.; or about 21 ounces of water free food elements.

In reply to the question, "What are nourishing substances? M. Germaine See remarks as follows: "A substance to be nourishing must furnish, in relation to its weight and volume, the greatest possible quantity of nutritive principles. Nutritive principles, as is well known, are themogenic elements. The second condition which must be met by a food is that it shall satisfy taste and hunger without producing too quickly the sensation of satiety. In addition to their nutritive and sensory qualities, foods must possess two other properties, viz., ease of digestion in the stomach, and readiness of absorption in the intestines.—*Bact. World and Mod. Med.*

Posture in the Treatment of Narcosis.—The next point to which I wish to call your attention is the limitations of the treatment of anæsthetic narcosis in so far as posture is concerned. It has become a favorite custom with many to invert partly or completely any patient whose respiration or circulation fails during anæsthesia. It goes without saying that this is only justifiable when heart failure is shown by marked facial pallor. If the respiration is at fault we should carefully avoid any inversion, because the presence of still more venous blood about the already exhausted respiratory center cannot aid it, but only injure it. By inversion we may distinctly interfere with the respiratory act by compression of the diaphragm through displacement of the abdominal viscera. This fact is particularly true in persons with large, pendulous abdomens, or in persons who have recently suffered or are suffering from tumors of the abdomen. By means of these growths the antero-posterior and lateral diameters of the chest in the neighborhood of the floating ribs are greatly increased, and the diaphragm is stretched and becomes more sail-like. Thus I have seen death follow the removal of a large ovarian tumor forty-eight hours after the operation, because the diaphragm, having no points of resistance on which to contract, because of the collapse of the lower part of the chest, simply rose and fell like a sail of a vessel coming about a useless organ, encroaching on the chest cavity during inspiration, and descending in such a way on expiration that little air passed out of the trachea. If any of you will place a rabbit under ether or chloroform, when tied flat on its back, so that its ponderous abdomen encroaches on its comparatively small chest, you will find that respiratory death quickly ensues, whereas in the erect position this does not occur. The pictures which I show you in this connection are taken of a rabbit held in such a way as to emphasize the movement of the abdominal contents in cases where these viscera are large and moveable.—H. A. Hare, M. D., in the *Medical Mirror*.

Indian Cholera Theories.—The debate at the Medical Society of London on December 5th, on the Indian experience of cholera, was remarkable for the strong evidence adduced that the old-world "air or monsoon theory," which has so long blocked the way, is becoming obsolete. The testimony of Dr. Simpson, of Calcutta, was crucial, and he was supported by Dr. Macleod, of Calcutta, and Mr. Macnamara, always an enlightened witness to the facts of water pollution. Mr. Macnamara made a good point and caused some amusement by saying, "Mr. Ernest Hart is wrong in declaring that the prevailing monsoons have no relation to the diffusion of cholera," then adding with quiet humor, "they effect its diffusion by blowing the boats down the river, which are manned by cholera-tainted crews, thus bringing about unexpectedly human intercourse." Such a debate, in which no voice was raised in favor of "the wind," and there was practical unanimity as to "water," should leave no doubt in the mind of the advisers of the Indian Government as to their duties and responsibilities in this great matter.—*British Medical Journal.*

Sulpho-Carbolate of Zinc in Typhoid Fever.—Dr. Ernest B. Sangnee, *Times and Register*, says: There is here a long, large, and filthy, alimentary canal to be disinfected; consequently, whatever antiseptic is used, I think that all should be given, the organism will stand. With the sulpho-carbolate of zinc, I am in the habit of giving to an adult five grains every three or four hours, until the temperature falls. So far, I have invariably found that, in from twelve to thirty hours the temperature falls from one to two degrees. Of course, I do not allude to the morning subsidence, I mean a positive reduction. The sulpho-carbolate of zinc, I believe, is not claimed *per se* to have antipyretic qualities. If such is the case, how else can the invariable lowering of the temperature be explained than on the ground that a portion of the irritation is removed? And, as we believe microörganisms to be the source of the irritation, it must be that some of them are either killed, or that the amount of their life activity is lessened.

By lessening the amount of irritation, we lessen the amount of poisonous ptomaines thrown into the system, and thus conserve a portion of the patient's vitality that would otherwise be lost. By this means we are more likely to keep him alive until the bacilli have run their course, because they have rendered their host unfit soil for further development.

The likelihood of tiding our patient over the critical deriod is thus enhanced, and the probability of restoring him to health and strength greatly increased.

SEXUAL PERVERSION.—The case quoted below from the *Omaha Clinic* shows that Omaha is a progressive city, and is entitled to be classed with Memphis.

A case reported as recently occurring in this city, in which T. M., a boy aged sixteen years, engaged in sodomy with a large Newfoundland dog. In attempting to extricate the swollen glans penis from the rectum of boy, the dog drags him about the floor of barn until firmly catching hold of some projecting object, the glans is extricated, tearing through the sphincter ani an inch into the gluteus muscle. The serious hæmorrhage following compels the boy to report to his mother, who called for medical aid. The wound was sewed up, healing on first intention.

INCOMPATIBILITY OF CALOMEL AND POTASSIUM IODIDE.—Dr. J. T. Carpenter, Jr. (*Philada. Polyclinic*) calling attention to severe burns of the conjunctiva by the instillation of calomel while giving potassium iodide internally, in course of his remarks states that the cases that came under his notice showed that although no permanent damage was done, the inflammatory reaction was severe and caused a muco-purulent conjunctivitis, accompanied by chemosis and œdema of the lids with great suffering.

The iodide is excreted by means of the tears and when calomel is instilled into the conjunctival sac, biniodide of mercury is formed, which is a severe caustic. It is in a large clinical service that this mistake is most likely to occur, where, owing to the number of cases and the short time in which to treat them, inquiries as to what medicine is being taken are apt to be neglected, but it may occur in one's private practice. Certain it is, that the custom is a practical one; *do not use calomel where iodine or iodides are being administered.—Med. and Surg. Reporter.*

TREATMENT OF DELIRIUM TREMENS WITHOUT CHLORAL, BROMIDE OF POTASSIUM OR OPIATES.—Dr. Norman Kerr, in *The Quarterly Journal of Inebriety* for October, asks "if delirium tremens was a morbid state, which was the issue of neurasthenia, or an effect of alcoholic poisoning. He believes it to be the latter, and that the disease arose from the cumulative specific action of a poison on the cerebral tissue through the alcoholization of the blood." Acting on this belief, his treatment is to eliminate the poison from the brain and nervous system, and leaving the healing power of nature to do the rest. He avoids alcoholic liquors and opiates, chloral, bromide of potassium and all narcotics. He gives as the only medicine liq. am. acet., at first every hour in drachm doses, and as nourishment, milk, beef juice, broth. Coffee was frequently given.—*Med. and Surg. Reporter.*

TREATMENT OF TONSILLITIS.—Tonsillitis, in the early stages, is readily amenable to mild treatment. For example, I have a patient, a young lady, who suffers from spasmodic asthma, the attacks being frequently brought on by indiscretions in diet, followed or not by exposure to inclement weather. She is given to wearing thin-soled shoes and light weight clothing, and has occasional attacks of sore throat, which have generally developed into tonsillitis. Now, however, these attacks can be promptly arrested by the exhibition of a solution containing mercury biniodide, gr. 1-25, and atropine sulphate, gr. 1-500, to four ounces of water, taken in teaspoonful doses at intervals of ten minutes during the first hour and at hourly intervals thereafter. Fever, increased pulse-rate, or chest pains, would of course call for other medications, such as aconite, gelsemium, or bryonia; a rheumatic diathesis would indicate the employment of the salicylates, and a malarial cachexia, quinine; while in the latter stage of the disease, under either condition assumed, calcium sulphide would prove most beneficial.—*Am Therapist.*

THE SPECIFIC GRAVITY OF THE URINE IN CASES OF DIABETES MELLITUS.—W. D. Halliburton (*British Med. Journal*) says that the fact that urine reduces Fehling's solution cannot be considered a trustworthy proof that it contains sugar. For purposes of life assurance or Government appointments, it is most important that this fact should be recognized. Sugar-testing should be carried out, however low the always specific gravity of the urine is. But without the confirmation of the fermentation test, Fehling's test is valueless. Uric acid, creatinin and hippuric acid, when in excess, produce a small reduction of Fehling's solution, but glycuronic acid when present (and it may be present without any serious pathological trouble) gives a heavy yellow or red precipitate, just as sugar does.—*Lancet Clinic.*

QUININE IDIOSYNCRASIES.—Dr. Joy F. Schamberg, *Univ. Med. Mag.*, reports the following unique case:

G. S., aged 55 years, married, while traveling abroad in the summer of 1889 was prescribed quinine by a physician whom he consulted for some trivial affection. About an hour after the administration of this drug he felt a burning pain in the end of the penis. The pain increased, and soon there developed a violent balano-urethritis, the meatus urinarius being occluded by pseudo-membranous exudation. The inflammation subsided under treatment in the course of three or four days. The patient naturally did not suspect the quinine as a possible etiological factor. Several months later this drug was again administered to the patient without his knowledge with precisely the same effect. During the summer of 1892 Mr. S. was advised by a druggist to take some quinine for a cold. Again a most troublesome balano-urethritis was produced in less than one hour. The causative influence of the quinine was then suspected and the patient was asked to repeat the dose as a test. This he refused to do on account of the painful nature of the inevitable consequence. Several months ago the patient received some pills from a physician on whom he called. In less than an hour after the ingestion of the first pill, symptoms of balano-urethritis appeared. He hastily consulted the druggist to ascertain the composition of his prescription, and found that each pill contained one grain of quinine. An attack similar to all the preceding ones was endured. The patient declares that he will never take a pill again without previously having an analysis made of it.

INHERITED INEBRIETY.—William Albert Heaslip, four years old, died suddenly under peculiar circumstances Sunday morning at his parents' home on the top floor of No. 398 Fifth Avenue. He was the younger of two children of John and Alice Heaslip, who have the care of the apartments and offices at this number. The child when very young was sub-

ject to cramps, and to relieve his pain the mother gave him small doses of whisky. A taste for alcohol was thus early planted in the infant, and when he learned to talk he would cry for whisky. Though the cramps were soon outgrown, the fondness for alcohol remained and was kept up by the parents every now and then yielding to the boy's abnormal and unnatural taste.

Some friends called upon the family Saturday night and whisky was opened. When they left, a bottle containing a heavy toper's "swig" was left uncorked on the table. While the parents were asleep Bertie arose early Sunday morning and, sighting the bottle with the familiar odor, drank the contents. When his parents awoke about 9 o'clock they found the child very sleepy and hardly able to stand. He was put to bed and quickly fell asleep. When he awoke a couple of hours later his appearance alarmed the father, who hurried for Dr. Charles H. Gulick, of No. 30 West Thirty-sixth Street. The doctor saw at once that it was a hopeless case of alcoholism. The child died in an hour. Deputy Coroner Jenkins will make an autopsy to-day.—*Journal of Inebriety.*

Pulmonary Emboli Following Mercurial Injections.—Interstitial injections of mercury, so largely used at present in the treatment of syphilis, are sometimes dangerous. Blaschko, quoted by the *Revue de Therapeutique Medico-Chirurgicale*, August 1st, 1892, reports two cases in which the injections of mercury were followed by pulmonary symptoms. In the first case, the patient complained of thoracic pain, coughed, and had accesses of oppression. On the day after the injection, the respiration became difficult, and the patient coughed bloody sputa. The second patient also complained of pain in the side, coughed, expectorated bloody sputa, and had a little fever. The symptoms in both cases disappeared in about three days. In a third instance, the patient had violent attacks of cough after the injection. These symptoms are explained by the author as being due to emboli caused by the paraffin employed as a vehicle for the mercurial preparations, which are insoluble, and are only suspended in the liquid. The writer believes that the mercurial injections give the best results in the treatment of syphilis, but that they must be administered by themselves, as in this manner they produce no untoward effects. The injections should not be so frequent in individuals affected with pulmonary troubles, especially phthisis.—*Therapeutic Gazette.*

Neuritis from Alcohol.—Dr. Drysdale of London in a recent discussion remarked as follows:

"The statement that alcoholic neuritis is more common with women than men, is not sustained by my experience. The changes which take place in these neurites are either interstitial or parenchymatous; the latter is the more common. The spinal cord is usually unaffected, but the muscles of the limbs are atrophied. The patient first complains of tingling of the extremities, of numbness, at first in the hands and feet, then extending to the legs; which gradually lose their power. The patient is usually apyretic, going about his usual occupations for a time, until, at last, he takes to his bed. The extensors first show a decided weakening of both the upper and lower extremity, the patient lying in bed with the toes pointed or exhibiting foot drop. The weakened muscles gradually atrophied, especially the anterior tibial, and interossei of the hand. These muscles do not react to interrupted current, and are variously affected by the cnntinuous current. Anæsthesia is marked in many cases, but occasionally the reverse is present. The muscles are tender to pressure for a long time, especially over the calf. The reflexes are absent, and the legs eventually become contracted and adhesions form round the joint. The patients are, as a rule, apathetic and without appreciation of their condition. Often this disease simulates locomotor ataxy when it effects the lower extremities specifically. It is distinguished from ataxy by tenderness of the muscles and dropping of the foot. In syphilis there is great tenderness of other parts of the body, especially as seen in female patients. The main point of treatment is cutting off the alcohol at once. Where rheumatism complicates the case, salicylate of sodium is of value. The continuous current is valuable in wasted muscles, and in cases much reduced a water bed is essential to prevent bed sores. The treatment is essentially a tonic and a building up one.—*Jour. of Inebriety.*

Infanticide by Means of Sponge.—Professor Paul Cazeneuve reports in *Lyon medical* for December 4, 1892, a case in which a healthy infant of five months died very suddenly. Seven months afterward, on account of popular suspicion, an examination was made of the putrid and anatomically unrecognizable massses constituting the head and the abdomen. In making an examination for arsenic, M. Cazeneuve noticed four rounded bodies, of the size of beans, that were elastic, and on further examination these proved to be pieces of sponge. On further search, three more pieces of sponge were found. Chemical tests failed to reveal the presence of any metallic poison in the remains, and no examination was made for alkaloidal poisons, on account of the putridity of the tissues. Professor Cazeneuve considered that the sponge had been administered to cause death, for in certain localities dogs and cats are killed by giving them sponge fried in oil. The sponge swells in the intestinal fluids, resists their action, and produces intestinal obstruction with vomiting and convulsions. It did not seem that the pieces of sponge had been swallowed by accident, as they were too numerous, and there is no domestic use for such small bits of sponge; They were probably administered in soup or milk with criminal intent. The author states that a method of infanticide in England is to stuff the pharynx of the new-born child with sponge held by a thread that permits of the removal of that substance after suffocation is produced. But he believes this case is unique in jurisprudence. The person accused of giving the sponge was found guilty and sentenced to hard labor for life.—*N. Y. Med. Journal.*

Therapeuties.

New Form of Iodine Treatment for Tuberculosis.—Dr. Renzi has given, in the *Revista Clinica e Therapeutica*, some facts regarding his new method of employing iodine in phthisical cases. His formula prescribes the use of iodine one part, iodide of potassium, three parts, chloride of sodium, six parts, and distilled water, 1000 parts. He injected this solution into the ear vein of healthy and also diseased rabbits, and into the subcutaneous tissue of rabbits, guinea pigs and dogs. Having in this manner care-

fully established the complete tolerance of the compound, he began to give it to his phthisical patients. Hypodermatic dosage was first tried with them, as much as 100 grains having been thus given. This method was not well borne, and the remedy was next tried by the mouth, the dose being from 500 to 550 grains. Nineteen patients, nearly all of them with advanced phthisis, were thus treated. Symptoms of iodism were produced in some patients, but did not persist long after a discontinuance of the doses. In all these persons there was an increase of appetite and of body-weight. There was an increased flow of urine, the temperature was brought down to normal, and the number of bacilli in the sputa was diminished. The writer believes that the results obtained from this plan of using iodine will compare favorably with those of any of the other treatments that are at present in vogue.—*Jour. A. M. A.*

CREOSOTE IN TUBERCULOSIS.—Dr. Stark, *Therapeutic Gazette*, in concluding his paper on "The Creosote Treatment of Tuberculosis," submits the following resume:

First. Creosote is no longer an innovation or a fad, but a drug which has come to stay as an antitubercular remedy.

Second. Creosote is particularly valuable in the earlier stages of tuberculosis.

Third. Its administration must be in moderate doses for a prolonged period.

Fourth. That it is a safe and reliable prophylactic in the condition that is usually described as pretubercular anæmia.

Fifth. It should be administered in combination with approved adjuvant remedies.

There are several easy and palatable methods of administration. The following prescriptions are ordinarily employed by me, the daily doses being dissolved in some alcoholic or vinous mixture, as whisky or sherry wine:

℞ Creosoti (beechwood).....mxlv
Glycerini.....ʒi.
Aquæ destil.....ad ʒii.
Dose.....ʒi t. i. d.

℞ Creosoti (beechwood).....ʒi.
Tinct. gentian comp.....ʒii.
Dose.....mxv t. i. d.

℞ Creosoti (Beechwood).....ʒss.
Bismuthi subnitrat.....ʒi.
M. et f. in capsul. no. xv.
Dose—One every four hours.

—*Medical and Surgical Reporter.*

COCAINE ANTIDOTES.—S. Mitchell (*Medical Record*) has found that while ammonia, digitalis and brandy will relieve the milder toxic manifestations of cocaine poisoning, they signally fail when these symptoms are superseded by severe præcordial pain, weak and rapid pulse, sighing respiration, borborymus and belching of wind, muscular rigidity, and later paralysis of the whole body except the brain, which is unnaturally active. In such a case he used a large teacupful of clear coffee, and has found it equally efficacious on subsequent occasions. It can be administered cold or hot. He makes no mention of amyl nitrite.

Gluck (Ibid.) advocates dissolving the cocaine in a 3 per cent solution of phenol. This, he claims, prevents the toxic effects of the former drug and renders the solution stable; as is well known, such solutions otherwise lose their anæsthetic effect after twenty-four hours. Phenol, besides, has a certain anæsthetic power of its own, forms a superficial eschar, which prevents absorption of the cocaine, destroys bacteria, fungi, etc., prevents decomposition in the solution, renders it aseptic and wards off reactive congestion.—*Med. and Surg. Reporter.*

THE TREATMENT OF DYSPNŒA.—Dr. M. Tournieux classifies the causes of dyspnœa as cardio-pulmonary, cardio-hepatic, and cardio-parietic. He places the toxic dyspnœas under the heading of cardiac dyspnœas, more particularly of arterial origin. The cardio-pulmonary dyspnœa, a dyspnœa of mechanical origin, when the phenomena of pulmonary stasis are predominant, is relieved by mild revulsives, or cupping, sinapisms as applied to the chest, rest, digitalis after a few days of a milk diet preceded by a saline or drastic purgative. Venesection, eight to ten ounces, may exceptionally be required. The digitalis should be administered in large doses, and should not be long continued; even better is the use of digitaline in that the action is more rapid. With cardiac disease, particularly of the arterial variety with active pulmonary hyperæmia, digitalis must be avoided, and intestinal derivatives and counterirritation over the chest be made use of. In dyspnœa of nervous origin varying modes of treatment must be employed; morphine given hypodermically, especially in the paroxysmal dyspnœa of those suffering from aortic disease. Albuminura is not in this instance a contraindication to its use, but a condition demanding that it be used prudently. In the dyspnœas of toxic origin the food must be as free as possible from substances producing ptomaines, eliminating those already in the intestines, and preventing them from entering the blood. The first indication is best fulfilled by milk, two or three quarts daily. Keeping the kidneys in activity—diuresis—meets the second, while the third indication demands intestinal antisepsis, which diminishes the work of the liver in its destruction of ptomaines that are produced. Here benzo-naphthol is a powerful agent to prevent fermentation, and, at the same time, according to Huchard, slightly diuretic. If the attack is very violent, cupping, injections of morphine, inhalations of oxygen, or especially inhalations of iodide of amyl, associated or not with chloroform, may be required. Besides, not only is the dyspnœa treated, but the causative pathological condition of which this is a symptom, the arterial sclerosis, must receive methodical and persevering treatment by the iodides. —*Revue generale de Clinique et de Therapeutique.—Pacif. Med. Jour.*

FOR NIGHT-SWEATS OF TUBERCULOSIS.—Neusser (*Jahresber d. Rudolph-Stiftung*) has reported the results of the employment of potassium tellurate in the treatment of the night sweats in a considerable number of cases of pulmonary tuberculosis. In the majority of cases the sweating was controlled or diminished. The usual dose was one-third of a grain given at bed time. In some cases a tolerance to the drug became established, so that the dose had to be doubled. In exceptional cases the appetite seemed to be impaired as the result of the medication; in some cases, too, a narcotic effect seemed to be produced. Toxic or unpleasant manifestations were exceptional. Most of the cases were well advanced in the disease, and no influence upon the general con-

dition was observed.—*Internationale klin. Rundschau, Pocif. Med. Jour.*

SOBERED BY APOMORPHINE.—Some time since I was hurriedly summoned to attend a man whom I found "crazy drunk," and possessed of decided homicidal tendencies. As he utterly refused to take any remedies by the mouth I administered one-twentieth grain apomorphine hypodermically, while two men held him in restraint. In a few minutes a child could have managed him, as he was vigorously engaged in trying to remove his boots by way of his stomach. A sleep of several hours followed, and he awoke sober. My only regret was that I did not double the dose.—*F. A. Cogswell, M. D., in Weekly Medical Review.*

CREASOTE IN WHOOPING COUGH.—Dr. Lerefait, of Rouen, has employed creasote in whooping cough, and reports very good results (*Wien. Med. Presse*). In every case where the disease has not already been complicated with a serious pulmonary affection—such as capillary bronchitis or pneumonia—when the treatment was begun, there was observed a gradual diminution in the frequency and intensity of the attacks, which in the end completely disappeared in from five days to six weeks, according to the severity of the case.

It was also found that the creasote cures the vomiting much faster than any other remedy. Even in the severer cases, where each attack was followed by vomiting, this symptom was arrested within twenty-four hours—a result in itself valuable, because it renders the ingestion of food possible, which enables the patient to more efficaciously combat the disease.

The creasote was prescribed in ½ per cent solution, the smallest dose given of this being three teaspoonfuls a day (in a child forty-four days old).—*Merck's Bulletin.*

THE COMBINED IODIDES IN THE TREATMENT OF SYPHILIS, ESPECIALLY OF THE NARES—In the July number of the *Revue de Laryngologie, d' Otologie, et de Rhinologie,* Dr. G. Darzens advocates a combination of the iodides of potassium, sodium and ammonium in cases of urgent specific disease where the prompt effect of the iodide is highly desirable. In a man of thirty-seven, with severe syphilitic lesions of the nasal fossa, who had been vainly treated by large doses of iodide, as well as other antisyphilitic remedies, he gave small doses of each of the three iodides and biniode of mercury, and obtained a most satisfactorily rapid impression without iodism or other unfavorable symptoms. He explains the result upon the idea that the other salts are eliminated more rapidly and the potassium iodide thus retained in the system until the others have disappeared, claiming that the kidneys execrete a limited proportion of any such salt and tend to retain the urine at approximately the same specific gravity. The intolerable headaches disappeared in a week, and the nasal lesions and dacryocystitis were practically cured in six weeks.—*Therapeutic Gazette.*

Obstetrics.

BISMUTH SUBNITRATE AS A DRESSING FOR THE NAVAL.—Dr. G. A. Stuart, of Wahu, China (*Medical News*), writes: For several years I have used bismuth subnitrate as a dressing for the umbilical cord in the new born. The method of application is as follows: Cut a piece of lint sufficiently large to fold over and prevent the bismuth from being dispersed. Through this a hole is made small enough to fit tightly about the cord and prevent dispersion at that point. The abdomen about the cord is dusted with the bismuth, the cord is passed through the hole in the lint, and the lint pushed well down upon the abdomen. Bismuth enough to completely bury the cord is applied, the lint is folded over smoothly and the binder applied. The advantages I claim for this mode over all others are the following: (1) Convenience. It has to be applied only once, as the cord immediately dries up, and does not need to be disturbed until it has dropped off. (2) Cleanliness. There is absolutely no odor, and the addition, at the time of the bath, of a little bismuth to places showing evidences of moisture will keep everything dry and sweet. (3) Safety. Mothers and nurses are not meddling with the dressing, since everything goes on satisfactorily. There is left no sloughing, no discharging stump to corrode the surrounding tissues and bring on hæmorrhage or predispose to hernia. (4) The cord drops off sooner than any other method. For small cords, three days; for large ones, five—rarely exceeding six—constitute the usual time. (5) A better and firmer cicatrix is left than any other method known to me. Since I have been using the bismuth dressing I have had no accidents, and 100 per cent of good results. Much depends upon the manner of dressing, and I have, therefore, somewhat minutely described its application.—*N. Y. Med. Times.*

Diseases of Children.

THE CRY IN THE DIAGNOSIS OF DISEASES OF CHILDREN.—The cry of children, according to Dr. E. C. Hill (*Denver Med. Times*), in pneumonia and capillary bronchitis is moderate, and peevish, and muffled, as if a door were shut between child and hearer. The cry of croup is hoarse, brassy, and metallic, with a crowing inspiration. That of cerebral disease, particularly hydrocephalus, is short, sharp, shrill, and solitary. Marasmus, and tubercular peritonitis, are manifested by moaning and wailing. Obstinate, passionate, and long continued crying tells of earache, thirst, hunger, original meanness, or the pricking of a pin. The pleuritic is louder and shriller than the pneumonic, and is evoked by moving the child, or on coughing. The cry of intestinal ailments is often accompanied by wriggling and writhing before defecation. Exhaustion is manifested with a whine. Crying only, or just after coughing, indicates pain caused by the act. The return or inspiratory part of the cry grows weaker toward the fatal end of all diseases, and the absence of crying during disease is often of graver import than its presence, showing complete exhaustion and loss of power. Loud screaming sometimes tells of renal gravel.—*Arch. of Gyn.*

BRONCHITIS IN CHILDREN. (*Mal. de l' Enf.*) *Acute Bronchitis.*—Is very frequent in children. May occur from the very commencement of life. Its most frequent cause is from "taking cold." It is often met as a secondary affection, particularly in measles, whooping cough and tuberculosis. Besides the

usual causes, in the adult there are others peculiar to childhood.

Dentition is often accompanied by a bronchial inflammation.

Bronchitis of intestinal origin.—This occurs frequently with gastro-intestinal dyspepsias with infectious diarrhœas.

Scrofulosis and Rachitis.—These are more frequently causes of chronic bronchitis than of acute.

Arthritis.—Is one of the most notable predisposing causes. In the children of gouty or obese parents, children who are fat, with high color, eczematous, the least sudden change of temperature produces an acute bronchitis.

Treatment should be to keep the child in a warm room (68°-72°) and administer bella donna or aconite with frictions of the thorax with a turpentine liniment. In severer forms of the disease one may use sulphate of quinine or antipyrine. In very young infants these may be given percutaneously in solutions or in ointment (frictions in the axillæ with an ointment of chlorhydrate of quinine). Mustard poultices may be alternated with the turpentine liniment. If necessary expectorant medication, ipecac, antimony, acetate or benzoate of ammonia. Jurasz has advocated apomorphine as an expectorant in doses of 1 c.g. per diem for the first year, two c.g. for a child of three years. Cafeine, by subcutaneous injections in doses 0.05 c.g., given several times in the twenty-four hours has been of great service in capillary bronchitis.

Chronic Bronchitis occurs as well in children of less than one year as in older. Often follows an acute bronchitis. The chronic state requires certain predispositions as poor nourishment, poverty, athrepsia, hereditary syphilis. A very large proportion of cases are in scrofulous children or children of scrofulous or tubercular parents.

Rachitis is a frequent cause attributed to the concomitant dilatation of the stomach.

Asthma may exist in children, particularly among the descendants of asthmatics (Trousseau) and we find an asthmatic bronchitis. *Chronic naso-pharyngeal lesions* may be causes. Repeated attacks of bronchitis have been noted after recovery from *tracheotomy*. The *presence of worms* in the intestine has been thought to be a cause. The *treatment* should be by emetic expectorants and counterirritants and by improving the general condition by aid of good hygiene, tonics, and above all by cod liver oil in large doses.

Chronic *pseudo-membranous bronchitis* may occur in children, particularly in the puny or phthisical. (P. Lucas-Championnière) D'Espine and Picot have observed one case in a child of thirteen years. Steiner describes a variety of chronic bronchitis under the name of *dry catarrhal bronchitis*. This is, according to D'Espine and Picot, a form of tuberculosis of the bronchial glands.—*Archives of Pediatrics.*

Structure of the Intestinal Canal in Children.—The *Archives of Pediatrics* reproduces the following from *Jahr. Kindevh:*

These investigations were of a purely anatomical character to determine in what way the intestinal canal differs in childhood and what influences any such differences in structure may have upon its diseases. Summing up, we find two peculiarities to be characteristic of the intestinal canal of the new-born: the slight development of the muscular layer and the relatively strong development of the mucous membrane throughout. The villi are sufficiently developed, more thickly placed ond more vascular than in the intestinal canal of adults. The number of glands of Lieberkhün relatively sufficient, the lymph system is at birth fully developed. These are the conditions required for the quick and easy absorption of nourishment in the growing infant. According to Benecke, the relative length of the intestinal canal, particularly the small intestine, is greater in nurselings than in adults; the intestinal surface and field for absorption are also greater. Physiological experiments prove that absorption takes place more quickly in young individuals.

Pathological transudates appear and disappear often very quickly in children. The delicacy of the mucous membrane, the number and size of the blood vessels and the richness in nerve elements cause a sensitiveness of the mucous membrane to different sources of irritation and cause the tendency to different inflammatory diseases and the slight resistance to them. Berg is of the opinion that, owing to the richness of the intestinal canal of children in blood, a severe irritation of the canal may cause illness or even death before any changes in its structure which could be recognized. The nerve plexuses are well developed by the myeline layer but the mesenterial nerves are not well developed.

We have, therefore, easy irritability and quick exhaustion with little possibility of resistance. These peculiarities of the nervous system in children cause the frequent colics. The weak development of the muscular layer causes the constipation. The dyspepsia in weakly developed children, particularly in those suffering from scrofula and rachitis, have their explanation in the weakness of the muscular coat of the intestine. The insufficient development of Brunner's glands must have an influence on the function of the intestine. No explanation of the mild and infrequent occurrence of typhoid fever could be learned from the study of Peyer's patches or of the solitary follicles.

Retention From Impacted Calculus in a Child.—R. B., two years of age, was admitted to the Children's Hospital, Nottingham, on October 10th, with retention of urine. When seen, at 6 P. M., the boy had a calculus impacted in the urethra, at the orifice, and his bladder was enormously distended. The stone was removed, and found to weigh three grains. After its removal no urine escaped beyond a few drops. A No. 6 gum elastic catheter was passed into the bladder when a very feeble stream ran out. Pressure above the pubes speedily increased this flow until six and one-fourth ounces of urine had been withdrawn. I have only once had occasion to do a perineal section for extravasation of urine in a child, and that was due to an impacted calculus. This boy seemed to have been very near to it. In these days of litholapaxy it may not be without benefit to know that in so young a child so much fluid has been retained without disaster.—*Brit. Med. Jour.*—*Arch. of Ped.*

"Blackeye" as a Complication of Whooping Cough—Dr. George Carpenter, *Arch. of Ped.*, reports the following:

Fredk. C., æt. 6 years, had been ill three weeks and whooped fourteen days. He had bronchitis,

The paroxysms were attended by hæmoptysis. The right eyelids presented a large dark hæmorrhage and in addition showed a general green discoloration underlying the skin. The whole of the ocular conjunctiva contained an effusion of red blood, with the exception of a narrow white ring surrounding the cornea.

When the subconjunctival hæmorrhage are present the blood does not extend quite up to the cornea, but is bounded by such a narrow ring as above described.

CARE OF THE NASAL PASSAGES IN CHILDHOOD—Dr. W. F. Srangways, *Physician and Surgeon*, the care of the nasal passages in childhood is greatly neglected, and the writer emphasizes the following facts: First, and very important, is the fact that every cold has a tendency to leave some chronic inflammation. Second, and very important, is the fact that every child which takes cold in the head easily or frequently suffers from some form of chronic rhinitis, which should be treated and cured, and until such treatment is given the child will be liable to cold from every slight cause. Third, it is very important for us to remember that the lumen of the nasal passage in childhood is very small and is easily destroyed by retained secretions. Fourth, all retained secretions act as irritants and perpetuate chronic rhinitis. A discharge from the nares does not invariably represent too free secretion. It more frequently represents an altered secretion, and occasionally a lessened secretion, where the currents of air take up the aqueous portion too rapidly, leaving the more solid parts to form a discharge.

The first step toward preventing and curing catarrhal troubles in the nasal passages is to gain good, vigorous health. Attention to food, exercise, clothing, baths, etc., is very important.

The next part of the subject is the medicinal. The nasal passages should be thoroughly cleansed with warm alkaline solutions, either by pouring the solution into the nostrils with a teaspoon, snuffing it from a sponge or the palm of the hand, or by using an atomizer. All crusts should be removed, and any diseased spots should be touched with some stimulating alteratives, as iodine or chromic acid.—*Arch. of Ped.*

Gynæcology.

ERGOT IN UTERINE HÆMORRHAGE.—"For acute hæmorrhage from the uterus I have found no remedy superior to ergot, though in chronic hæmorrhages the best remedy is gossypium, made into a decoction by taking three heaping teaspoonfuls to one pint of water and boiling for fifteen minutes; when cold, one-third of this is to be taken three times a day. This remedy is very useful in uterine hæmorrhage, even when due to fibroids or to cancer. If hæmorrhage be present, or there is any tendency to it, in my opinion iron only aggravates the condition. Apostoli's method of galvano-chemical cauterization is also very valuable. A very strong galvanic current is applied to the uterus with the positive pole."—*Garrigues in Post-Graduate.*

THE CURETTE IN UTERINE SURGERY.—A paper by Dr. Vanderveer, of Albany, N. Y. (*Pittsburgh Medical Review*), thus sums up the conditions for the relief of which the curette is indicated.

Prolonged hæmorrhage in girlhood, womanhood, adult life, advanced age:

Hæmorrhage from small or large fibroids, and from hydatids.

Hæmorrhage from endometritis fungosa at any time in life.

Septic conditions following miscarriage or full term delivery.

Subinvolution—chronic metritis—acute or chronic endometritis associated with or without laceration of the cervix. Many cases of laceration of the cervix require a short time previous to the operation for repair, a careful curetting.

Cases of painful menstruation, due to cervical stenosis, and where it is determined to wear after dilatation, an intrauterine pessary.

Cases of retro and anteflexion, causing great enlargement of the body of the uterus.

NOTE—Curetting the uterus is rapidly becoming as fashionable and as universal an operation as laparotomy, and we venture the prediction that the uterine cavity will be released from operative thraldom ere long. In fact, the contention must be allowed, that in some of the conditions enumerated above, other and simpler remedies will suffice to attain a favorable result. What for instance is to be gained by curetting the uterine cavity—in cases of uterine stenosis? Because a stem pessary is to be worn? Is it not a fact, that the retro-stenotic conditions of the mucous membrane are *directly* due to the stricture, and that the uterus will recover at once, as soon as the stricture is relieved? And suppose the mucous membrane is changed by a chronic endometritis, will not a thorough swabbing of 1 part of iodine to 4 parts of glycerine relieve the conditions at once?

And what indeed is to be gained by curetting a uterus in which the pathological conditions are due to mechanical causes? Why not relieve the cause? Does the curette do so? And if the mechanical deviation must remain, is it not a disadvantage to continually irritate the organ under such adverse circumstances?

The writer of the paper is certainly an authority worthy of confidence, yet the objections offered seem to be in place.—*Journal Mat. Med.*

THE INTRAUTERINE USE OF IODINE AND IODOFORM —The tincture of iodine and the iodized phenol both coagulate the albuminous fluids on the surface of the mucosa, and in so doing cauterize this surface and so form an eschar. Thus, as with other caustics, some diseased issue is destroyed. The iodine, before absorption, unites with the albumen of the secretions and thus usefully exerts a "starving" influence on the morbidly developed tissues of uterine catarrh and granulating ulcerations.

This characteristic effect of iodine should be more distinctly obtained from iodoform than from tincture of iodine. Iodoform contains ninety-six per cent of iodine, yet it is not caustic, only denutritive and antiseptic. The other iodine preparations are caustic, that is, they coagulate secretions and destroy the superficial layers of tissue, producing an irritation in the vicinity of the point of application and causing an active dilatation of blood vessels with its consequence.

The indications for choice between two remedies

may therefore thus be formulated. When it is desired to obtain the remote effect on the parenchymatous circulation of the uterus which results from cauterization of the endometrium, iodine tincture or iodized phenol is required. When a superficial action only is required on abraded hyperæmic surfaces, or on ulcers with papillary granulations, iodoform is preferable. Iodine is indicated for the uterine cavity and infrequently, iodoform for cervical catarrhs and ulceration of portio vaginalis and may be employed frequently.—Dr. Mary P. Jacobi in *Amer. Journal of Obstetrics.*

Ophthalmology.

Treatment of Pain in Eye Diseases.—Dr. E. Jackson (*La Semaine medicale*, No 64, 1892) presents the best means of treating pain in ophthalmic diseases as follows:

Pain of conjunctival origin.—Inject a weak solution of nitrate of silver. Bathe the eye in very hot water for a short time. Cocaine is only to be used when other means have failed, as its action is very short and it has an injurious influence upon the cornea. Avoid all occlusion of the eye by bandages, as this only increases the pain and photophobia, especially where the disease is of a phlyctenular nature.

Pain of corneal origin.—Employ one of the two following solutions:

℞ Neutral sulph. atropine,)
Muriate of cocaine, (aa cgms. 5.
(gr. j).
Distilled water, ... gms. 8.
(℥ij).

Instil one drop of this solution into the eye every four to six hours.

℞ Sulphate of eserine . . . . . mgms. 7
(gr. ⅛).
Muriate of cocaine, ... cgms. 10
(gr. jss).
Distilled water, ... gms. 15
(℥iv).

Instil a drop into the eye every four to six hours.

The former preparation is of especial use in recent corneal lesion, as well as where a complication of the iris is suspected, while the second is valuable in corneal ulcerations. Small compresses dipped into very warm water and applied to the lids are a serviceable means of combating corneal pain.

Pain from inflammatory hyperæmia.—When the pain is due to an iritis, irido-cyclitis, and certain states consecutive to traumatic lesions of the eye, nothing calms it as quickly as local blood-letting, fifty to sixty grammes (1½ to 2 ounces) of blood being drawn from the temples by means of leeches or cupping. Applications of ice or iced compresses are of great service, but, as a rule, only in young and robust subjects. They should be used for a long time and continually, and not intermittently or for a brief period.

Neuralgia.—This is most frequently due to asthenopia, consecutive to anomalies of refraction. It should be treated by correction of the faulty vision, though it may be relieved by a mydriatic.

Glaucoma.—Temporary relief may be obtained by instillation of eserine. Operative treatment is, as is well known, the most efficacious. *Lancet Clinic.*

Ocular Headaches.—Ocular headaches come from ocular strain, and ocular strain comes from extraordinary and unnecessary effort being required to enable the eyes to perform their ordinary duties. The characteristics of an ocular headache are that they follow near work or come on during near work. Perhaps the most common form is a headache in the morning, after long continued use of the eyes in the evening. Ocular headaches almost always follow railroad journeys, visits to the theater, walking in crowded streets, visiting in picture galleries, or any other use of the eyes which requires unwonted exactness of vision. Such a headache is first of all frontal, very often temporal, and with or without pain in the eyes. The next most common place for such headaches is in the occipital region. A headache that is frontal and occipital is almost always ocular. The treatment of ocular headache is, of course, the correction of the eye strain, and this in the vast majority of cases means proper glasses.—*Boston Med. and Surg. Journal.*

Treatment of Trachoma.—The writer comments adversely on some of the severer forms of treatment, especially the excision of the retro-tarsal folds, and Manolescu's—that of scarification and scrubbing the bleeding surface with a stiff toothbrush dipped in a strong solution of corrosive sublimate ($\frac{1}{500}$). These the writer deems unnecessary cruelty. He then describes Hotz's method of expression. Hotz's description leaves out some of the steps which contribute to its success. The whole process as given by the writer is first eversion of the lids. Here care must be taken to evert the cul-de-sac; the patient being directed to look downward, the upper lid is everted the usual way; then to make it complete, draw the everted lid upward, pressing firmly backward through the lower lid upon the globe with the other hand; as the eye is pressed backward the folds evert beautifully; now while the thumb or forefinger of the left hand holds the lid everted, the thumb or forefinger of the right hand is inserted under this lid with the palmar surface toward the globe and made to glide slowly forward from under the trachomatous folds; the two thumbs pressing steadily and continuously will force out the contents of the trachomatous follicles. By repeating this process several times all the diseased follicles can be expressed in one treatment. The application of expression to the lower lid is accomplished by gathering a fold of the conjunctiva between the arms of an oldfashioned curved iris forceps; as the follicles pass through the arms the diseased follicles are expressed. Wherever a trachoma follicle is seen it should be subjected to this expression. This pressure should never be sufficient to bruise or injure the healthy parts. It is surprising, as well as satisfactory, to see the jelly-like masses exude. The other severer forms all are followed by the drawbacks of scar tissue, none of which should be found after this method. Hotz's method should be done under cocaine. Short applications of cold water always suffice to alleviate pain, and in two or three days the usual medicines may be applied as simple conjunctivitis chronic or catarrhal require. Hotz credits Dr. E. Mandelstamm and Dr. P. D. Keyser each with independently originating similar treatments.—*Ophthal. Rec'd.*

Appearance of the Eyes in Disease.—The eyes (*Times and Reg.*) are congested in variola, scarlet

fever, rubeola, yellow fever, typhus fever, meningitis. They are projecting in asphyxia, hydrocephalus, hydrophobia, exophthalmic goitre, and sometimes in functional heart disease. They are sunken in collapse, cholera, and hectic. They are staring in convulsions, apoplexy, meningitis, and dementia. They are rolling in catalepsy and tuberculosis meningitis. They are photophobic in hysteria, meningitis, and cephalalgia. The pupils are dilated in syncope, hysteria, collapse, asphyxia, epilepsy, drowning, uræmia, coma; generally in phthisis, poisoning by belladonna, atropia, fungi, and many vegetable irritants and narcotics. They are contracted in concussion, sunstroke, typhus fever, hæmorrhage of the pons; in poisoning by opium, morphine, prucic acid, calabar bean, ergot of rye, and pilocarpine. At first contracted and afterward dilated in compression of the brain, in poisoning by alcohol, ether, and chloroform. At first dilated and afterward contracted in severe apoplexy. They are unequal in paralysis, compression of the brain, and posterior spinal sclerosis. They are frequently oscillating in epilepsy, typhus, and spinal sclerosis. In diseases of the eyes external signs facilitate diagnosis. Congested in conjunctivitis, trachoma, ophthalmia. Dilated in mydriasis, glucoma, and amaurosis. Contracted in myosis, retinitis, and iritis. Photophobic in strumous ophthalmia, amaurosis, iritis, sclerotisis, choroiditis, and retinitis.

Toxicology.

Sulphonal Poisoning.—The *Wiener Klinische Wochenschrift*, No. 36, 1892, publishes the following abstract of Geolle's article read at the Chemico-Physical Society of Vienna:

1. The peculiar red-brown color of the urine after sulphonal poisoning is due to the presence in the urine of hematoporphyrin.
2. For the discovery of hematoporphyrin the spectroscope may be used, the substance showing in solutions of hydrochloric acid and ammonia.
3. A useful clinical test is the precipitation of the coloring matter by an alkaline solution of chloride of barium, and treatment of the precipitate with alcohol containing hydrochloric acid. The resulting solution is marked by the presence of the absorption bands.
4. It is doubtful whether the substance circulates in the blood or not.
5. After sulphonal intoxication there is a trace of albumin and a few renal elements in the urine.
6. A small amount of unchanged sulphonal may be found in the urine.
7. The greater part of the sulphonal is excreted in the form of soluble ununited sulphuric acid.
8. Neutral sulphur compounds cannot be discovered in the urine.

From these observations the author concludes that the sulphonal must be stopped as soon as the color due to hematoporphyrin appears in the urine.—*Univ. Med. Mag.*

Hyoscyamus and Atropine Poisoning.—Rudolph (*Centralbl. f. Klin. Med.*, October 8, 1892), reports four cases of henbane and one of atropine poisoning. The former occurred in four brothers, aged eleven, nine, seven and five years respectively, who had eaten the seed capsules. Symptoms common to all four were red face, dilated pupils, dry lips and mouth, restlessness and mental excitement. In one case the symptoms were but slightly marked. In the boy aged five there was a period of marked apathy preceding the excitement. In only one case was there a rise of temperature (38.3° C.); and in another case there was a scarlatiniform eruption on the thorax, and especially on the buttocks. In no case was the pulse more than 110. In two days' time all the boys were discharged well, but with dilated pupils. The treatment consisted in washing out the stomach and the subcutaneous injection of morphine. The case of atropine poisoning occurred in a woman aged thirty. She was brought in by the police, who thought her insane. She was rambling, and her gait was uncertain. The face was red, the pupils widely dilated, the lips and mouth dry, the pulse 132, and the temperature normal. The fæces and urine were passed unconsciously. The stomach was emptied, and atropine found in the contents. Morphine was injected. In twenty-four hours her mind was clear, and she was discharged well on the following day. The symptoms of atropine and hyoscyamus poisoning are almost alike. The mental condition is one of excitement, combined in henbane poisoning with hallucinations. These hallucinations may be absent in atropine poisoning. The tendency to sleep in the former condition was not noted at the beginning of any of the cases, but the deep coma in the boy aged nine the author would attribute to the action of the poison, and not to the small dose of morphine given. In this condition the pupils, as in ordinary sleep, were minutely contracted. Morphine is a very useful remedy to overcome the mental excitement, but it should not be given in too small doses.—*British Medical Journal.*

A Case of Poisoning by Methylblue.—An engineer was suffering from a typical attack of malarial fever and was treated with arsenic and quinine without success; received some benefit from the use of strychnia. After consulting another physician later he ordered methylblue, three or four times daily 0. 2 grm. On the second day there was difficulty of urination and vomiting; notwithstanding this he continued taking the medicine. In the following few days these symptoms increased; urination became more painful accompanied by some bleeding. After six days the treatment was stopped and the symptoms of poisoning disappeared in a few days.—(*Wein. Aerztl. Centr.-Anz.*)—*Med. and Surg. Reporter.*

Locomotor Ataxia Caused by the Use of Morphine.—At the meeting of the society of German naturalists and physicians (*Wein. Klin. Wöchensch.*), Althoff reported that he had observed a peculiar ataxic phenomena in dogs that had during a long period received subcutaneous injections of morphine. The reason he found to be a degeneration of the posterior columns of the cord in the dorsal region. Specimens were shown. The color of these columns is gray to the naked eye. Microscopically there was found in them complete or almost complete absence of axis-cylinders, consequently degeneration of the same. This is the first instance in which a system disease of the cord has been artificially produced in the dogs, and at the same time explains the existence of tabetic symptoms in many instances of morphine habitues.—*N. Y. Med. Times.*

Materia Medica.

CRYSTALLIZED KNOWLEDGE. CLASSIFICATION OF PREPARATIONS.—*Solids.*—abstracts, resins, pills, confections, triturations, ointments, plasters, extracts, masses, troches, powders, papers, cerates, suppositories.

Liquids.—Waters, mucilages, syrups, infusions, decoctions, solutions, mixtures, honeys, fluid extracts, tintures, wines, spirits, elixirs, oleo-resins, collodions, vinegars, liniments, oleates, glycerites.

Semi-Solids.—Confections, plasters, oleates, cerates, liniments, extracts, suppositories, ointments.

Comparison of Weights and Measures.—Metric and apothecaries. Gramme equals 15.5 grains; 0.1 equals 1.5 grains; 0.01 equals .15 (or 1-6) grain; 0.001 equals .015 (or 1-64) grain; 1 gr equals .06 gramme; 1 dr. equals 4.0 grammes: 1 oz. equals 32.0 grammes; 1 c. c. equals 15 min. or ¼ fl.-dr. (approximately).

Young's Rule for Dosage.—Add 12 to the age, and divide by the age, to get the denomintor of the fraction, the numerator of which is 1. Thus for a child two years old, 2 plus 12 divided by 2 equals one-seventh.

AID IN MEMORIZING DOSES.

1. The dose of all infusions is 1 to 2 ozs., except digitalis, which is 2 to 4 drams.
2. Of all poisonous tinctures, 5 to 20 mins., except tinct. of aconite, dig. and nux. which is 1 to 5.
3. Of all wines, from ½ to 1 fl.-dr., except wine of opium, colch. rad., which is 5 to 15 mins.
4. Of all poisonous solid extracts you can give ½ gr., except extract of calabar bean and cannab. ind., which is 1-16 to ¼ gr., ext. belladonnna, ¼ gr.
5. Of all dilute acids, from 5 to 20 mins., except dilute hydrocyanic acid, which is 2 to 8 mins.
6. Of all waters, 1 to 2 fl.-oz., except aqua lauro cerasus and aqua ammonia, which is 10 to 30 mins.
7. Of all syrups, 1 dr.
8. Of all mixtures, ½ to 1 fl.-oz.
9. Of all spirits, ½ to 1 fl.-oz.
10. Of all assential oils, 1 to 5 mins.

Taken from Clifford's Manual of Mat. Med., Ther., and Pharmacy.

SUBSTANCES INCOMPATIBLE WITH ANTIPYRIN.—The following substances precipitate antipyrin from its aqueous solutions.

1. Concentrated solutions of carbolic acid.
2. Tannin, and preparations containing tannin.
3. Tincture of iodine.
4. The chlorides of mercury.

The following substances, when triturated with dry antipyrin, decompose it:

1. Calomel which forms a toxic compound with antipyrin.
2. Betanaphthol.
3. Chloral hydrate, which forms an oleaginous liquid with it.
4. Sodii bicarbonas, which when brought in contact with it sets free an odor of acetic ether.
5. Salicylate of soda, which also forms an oleaginous compound with it.
6. The salts of quinine and caffeine, which have their solubility increased by antipyrin.—*Gaz. des Hospitaux—Canad. Pract.*

Diseases of Women.

VARICOCELE IN WOMEN.—A late work on the subject by M. Roussan, who had seen the cases in Dr. Possi's wards, explains this malady which is called "*pelvic varicocele.*" It has been noticed, in making laparotomy and hysterectomy, and in autopsies made on women, that varicose dilatations of the pelvis are very common, just as hæmorrhoids and varicose veins of the legs are in women. Pelvic varicocele comes from any cause that brings about any interference with the venous circulation of the pelvis, such as tumors, cysts of the ovary, as well as the large class of fibroids, etc. There is also a general state that predisposes to this malady; a sort of atony of the smooth fibers of the muscular structure of the veins. which is very often under the influence of certain diseases. The symptoms of varicocele in women are analogous to those in man; pain in the left side of the pelvis, running downward into the groin and back upward to the lumbar region, with feeling of weight in the part, mostly felt at the monthly period. It goes away when the patient is lying down, and comes back when she walks. In making an exploration, varicose veins may be seen on the labia majora and the finger will find a tumor that is soft and painful to pressure. This will be more prominent when the patient is standing. By the rectal touch it can be felt very well, and may be taken for salpingitis. The symptoms are not very evident in many cases but the malady should be sought for, however, in all varicose cases. The treatment must address itself to the cause, but in case of pain, rectal injections of laudanum solutions are ordered, while the patient is kept in bed. To diminish the congestion and help the circulation along, hot water rectal injections are used, with a rectal sound that will carry water some eight or ten inches up; a small porcelain ring is held in the anus to allow the water to flow away, and as much as five or six quarts are used. A vaginal tampon is also advised, to make compression on the vessels. Hydrastis canadensis and hamamelis are given internally.—*Med. Fortnightly.*

ANNOUNCEMENTS.

AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

CHICAGO, January 19, 1893.

To the Editor WESTERN MEDICAL REPORTER:

Dear Sir: At the second annual meeting of the American Electro-Therapeutic Association, the following officers were elected for the ensuing year:

President, Dr. Augustin H. Goelet, 531 West 57th Street, New York; first Vice President, Dr. Wm. F. Hutchinson, Providence, R. I.; second Vice President, Dr. W. J. Herdman, Ann Arbor, Mich.; Secretary, Dr. Margaret A. Cleaves, 68 Madison Avenue, New York; Treasurer, R. J. Nunn. 119 York Street, Savannah, Ga.

The third annual meeting will be held in Chicago on September 12, 13 and 14, 1893. A cordial invitation is extended to all members of the profession interested in electro-therapeutics. Arrangements for special rates on railways and at hotels are in progress.

The committee of arrangements will be obliged if those who intend being present at the meeting, will

send their names, the class and amount of accommodation required, titles of papers to be presented, applications for membership, etc., at as early a date as possible. Accommodation should be secured early on account of the crowded condition of the hotels, because of the World's Fair. All communications should be addressed to the Secretary.

The committee will be glad to furnish any information in regard to the meeting upon application.

The Committee of Arrangements,

FRANKLIN H. MARTIN, Chairman. S. C. STANTON, Secretary.

AN ARMY MEDICAL BOARD.—Will be in session in New York City, N. Y., during April, 1893, for the examination of candidates for appointment to the medical corps of the United States Army, to fill existing vacancies.

Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before March 15th, 1893, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidate must be between twenty-one and twenty-eight years of age, and a graduate from a regular medical college, as evidence of which, his diploma must be submitted to the Board.

Further information regarding the examinations may be obtained by addressing the Surgeon General U. S. Army, Washington, D. C.

C. SUTHERLAND,
Surgeon General U. S. Army.

ST LOUIS, Mo., Jan. 16, 1893.

PRELIMINARY MANIFESTO OF THE SECTION ON DISEASES OF THE MIND AND NERVOUS SYSTEM, PAN-AMERICAN MEDICAL CONGRESS.

Honorary Presidents: Dr. Jorge Diaz, Albertina, Havana, Cuba; Dr. Juan C. Castillo, Lima, Peru; Dr. C. G. Comegys, Cincinnati; Dr. F. X. Dorcum, Boston; Dr. J. T. Eakridge, Denver, Col.; Dr. Orpheus Everts, College Hill, Ohio; Dr. Juan N. Covantes, City of Mexico, Mexico; Dr. Allen McLane, Hamilton, New York; Dr. Wm. A. Hammond, Washington; Dr. P. O. Hooper, Little Rock, Arkansas; Dr. Henry N. Hurd, Baltimore; Dr. J. G. Kiernan, Chicago; Dr. J. A. McBride, Wauwatosa, Wis; Dr. Chas. K. Mills, Philadelphia; Dr. Moncorvo, Rio de Janeiro, U. S. Brazil; Dr. Putnam, Boston; Dr. E. C. Seguin, New York; Dr. E. C. Spitzka, New York; Dr. G. Isaac Ugarte, Santiago, Chile; Dr. Samuel Webber, Boston; Dr. Joseph Workman, Toronto, Canada.

Executive President: Dr. C. H. Hughes, 500 North Jefferson Avenue, St. Louis, Mo.

Secretaries: Dr. A. B. Richardson, (English-Speaking), Columbus, Ohio; Dr. M. C. Echeverria (Spanish-speaking), Key West, Fla.; Dr. Melendezy, Caorea (Nospicio, San Buenaventura), Buenos Ayres, Argentine Republic; Dr. Nicolas Hortiz, La Paz, Bolivia; Dr. Carios Eires, Rio de Janeiro, U. S. of Brazil; Dr. Stephen Lett, Guolph, Canada; Dr. Plaloo, Kingston, Jamaica, W. I.; Dr. Paolo Garcia Medina (Carrera S, No. 277) Bogota, Republic of Columbia; Dr. Emillano, Nunez (Galiano 19), Havana, Cuba; Dr. Jose Azurdia, Guatamala City, Guatemala; Dr. George Herbert, Wailuku Maui, Hawaii; Dr. Secundino E. Sosa (Hospital de Mujeres Domentes), City of Mexico, Mexico; Dr. Pellais, Leon, Nicaragua; Dr. Hemiterio Formez, Merida, Venezuela; Dr. Francisco Soca (Florida 90) Montevideo, Uruguay.

Every effort is being made to make the meetings of the section on diseases of the blind and nervous system both scientifically profitable and socially pleasant. Papers of distinguished merit from neurological students and physicians eminent in psychiatry have been promised.

Every phpsician on this continent of America, north or south, is hereby cordially solicited and welcomed to join in the meetings of this important section of the approaching Pan-American Medical Congress; and it is hoped by unity of effort and cordial coöperation to make the section of nervous and mental diseases second to none in the congress in fruitful results to Pan-American Psychiatry.

Let us come together from all the Americas and make the coming convocation one long to be remembered for its scientific and social benefits to all.

Fraternally,
C. H. Hughes,
Executive President Section of Diseases of the Mind and Nervous System.

PUBLISHER'S DEPARTMENT.

Approved Formulæ.

The very general approval accorded to the American Antipyretic and Analgesic, Antikamnia, as well as the lively interest the clinical reports upon its therapeutical value has excited, induces us to furnish our readers with the following formulæ for the purpose of indicating a few of the more generally used combinations:

TONIC IN PAINFUL ATONIC DYSPEPSIA.

℞ Antikamnia.....3iss.
Tinct. Nucis Vom .....3i.
Tinct. Gentian Comp.....ʒii.
Syr. Sarsap. Comp.....ʒiv.
M. Sig.: One teaspoonful three times a day, after meals.

—OR—

℞ Antikamnia.....grs. lxxii (72).
Extr. Nucis Vom.....grs. vi.
Extr. Gentian.....grs. xii.
Quin. Muriat.....grs. xxxvi.
Pulv. Aloes.....grs. ii.
Extr. Belladona.....grs. iss.
M. Ft. Pil. Num. xxiv.
Sig.: One three times a day.

HYSTERIA.

℞ Antikamnia.....ʒss.
Alcohol.....3i.
Elix. Ammon. Valiran ad.....ʒvi.
M. Sig.: One teaspoonful three times a day.
An admirable remedy in the treatment of colds is the following:

℞ Salol.
Antikamnia.
Sulph. Quinia.
Terpin. Hydrate.....aa grs. xxiv (24)

M. ft. Capsules xii. One every four hours. This seems to be a large quantity, but if put in 10-gr. capsule it can be taken readily and is usually very well borne by the digestive organs.

BRONCHITIS.

℞ Antikamnia... .....3ii.
Liquor Ammon. Acet.....ʒiss.
Mist. Glycyrrh. Comp.....ʒiv.
Extra. Rad. Glycyrrh. fld. ad.....ʒvi.
M. Sig.: Two teaspoonfuls every three or four hours.

FOR COUGH,

℞ Antikamnia.....3i.
Salol.
Quin. Sulph..... ..aa grs. xx.
Spts. Frumenti..... .....ʒiii.
Syr. Tolutan .....ʒi.
Syr. Simplex.....q. s. ʒvi.
M. Sig.: One teaspoonful every hour until cough is relieved.

TO RELIEVE THE PAIN AND BURNING IN BOTH ACUTE CHRONIC CYSTITIS.

℞ Antikamnia and Salol Tablets aa grs. v. Num. 24.
Sig.: One every three hours.

INTESTINAL ANTISEPTSIS.

℞ Antikamnia and Salol Tablets aa grs. v. Num. 24.
Sig.: One every two or three hours.

IN THE GASTRIC CATARRH OF DRUNKARDS.

℞ Antikamnia and Quinine Tablets aa grs. v. Num. 24.
Sig.: One every two or three hours.

IN TYPHO-MALARIAL FEVER.

℞ Antikamnia and Quinine Tablets aa grs. v. Num. 20.
Sig.: Two every three hours.

FOR PAIN.

℞ Antikamnia ....3ii.
Alcohol.....3ss.
Tinct. Cardam. Comp.
Syr. Zingib.....aa ad. ʒiii.
M. Sig.: One teaspoonful every three to four hours.

FOR PAIN IN LADIES AND CHILDREN.

℞ Antikamnia.....3iis—3ii.
Elix. Simplici.....ʒvi.
M. Sig.: Two teaspoonfuls every four to six hours.

BOOK REVIEWS.

"The Diseases of the Stomach." By Dr. C. A. Ewald, Extraordinary Professor of Medicine, at the University of Berlin; Director of the Augusta Hospital, etc. Authorized translation from the second German edition with special additions by the author, by Morris Manges, A. M., M. D., Attending, Physician to Outdoor Department, Mount Sinai Hospital, New York City, etc. New York: D. Appleton & Co., 1892.

This work represents Vol. 11 of Prof. Ewald's "Klinik der Verdauungskrankheiten", translations of which have already appeared in the Russian, Italian, and Spanish languages. Additions have been made to the notes of the translator, by Prof. Ewald himself, so that practically this volume represents what will be issued as the third of the German editions. The style of the lectures, largely clinical, make the book very interesting to the reader, the lecturer referring to many facts that are not as a rule found in any of the text-books.

The book gives much practical information on diseases of the stomach, as the author has spent many years in experimental and clinical work, and the translator without sacrificing the original language, more than was necessary, has done excellent work in this English translation. A few notes are added in the text or at the bottom of pages, but most of these refer to some of the investigations made since the publication of the last German edition.

Pamphlets and Reprints.

Quarantine Control, State or National. The question. A speech delivered before the Chamber of Commerce and Industry of Louisiana, New Orleans, Jan. 11, 1893, and respectfully submitted to the Honorable the Senate and House of Representatives in Congress Assembled. By Joseph Holt, M. D.

The Element of Tension in the Treatment of Large Abscesses. By A. E. Hoadley. M. D. Reprinted from *The Chicago Medical Recorder.*

Arterial Saline Infusion, a report of three additional cases, by the new technique; also, a case of infant diarrhœa treated by saline infusion. By Robert H. M. Dawborn, M. D. Reprinted from *The Medical Record.*

Clinical Reports on Insanity. By the Medical Staff of the Maryland Hospital for the Insane.

I. The relation of pelvic disease and psychical disturbances in women. By George H. Rohé, M. D.

II. A case of trephining for Insanity. By J. Percy Wade, M. D.

III. A case of showing the relation of kidney disease to insanity. By Milton D. Morris, M. D.

IV. Acute delirious mania, probably depending upon Septic Absorption. By Fred Caruthers, M. D.

V. Results obtained with sulfonal and hyoscine in the treatment of the insane. By John H. Scally, M. D. Extracted from the ninety-fifth aunual report of the Maryland Hospital for the Insane.

When shall we Trephine in Fractures of the Skull? By Emory Lamphear, M. D., Ph., D. Reprinted *Kansas City Medical Index.*

Report of an Operation for Removal of the Gosserian Ganglion. By Emory Lamphear, M. D., Ph. D. Reprinted frm the *International Journal of Surgery.*

MISCELLANEOUS.

BED-CLOTHING FOR THE SICK.—In hospital as well as in private practice, great errors are made in the matter of bed-clothing for the sick, and particularly for the sick who are suffering from febrile affections. We have got rid of the heavy curtains around the bed; of that grand accumulator of dust and other uncleanliness, the tester; of the heavy valance which converted the under part of the bed into a close cupboard, in which all kinds of unwholesome and cumbrous articles lay concealed, including sometimes excreted matter itself; and we have banished the carpet, which often, as a hard-trodden, dust-laden rag, made the floor beneath the bed persistently impure. This is all good reform, but we have still not advanced sufficiently in the reforms necessary for bed and bedding. The old feather beds, flock mattresses, heavy blankets, thick, impermeable and dense counterpanes still encumber many a patient, rendering ventilation of his body as impossible as in the

days of our fathers. It does not indeed seem as yet to have been accepted by physicians, still less by nurses and patients, that the body calls for ventilation; that a bed room or ward may be the purest in a general point of view, and yet that the advantage which ought to arise may be considerably curtailed by the unwholesomeness of the bed and bedding, and by the patient making an unwholesome atmosphere for himself in his immediate surroundings. The universal improvement that is now called for in the direction named consists in substituting porosity for density in all articles of bedding. The thick, dense bed and mattress require to be replaced by the light steel elastic bed; and the clothing under and upon the patient, now so close and heavy, require to be replaced by clothing that is porous, so that it can be permeated with pure air from without, and can at the same time permit the warm and impure air from the patient to have free exit. Under such a condition of clothing there is a double current of gases going on in the clothes, which is most purifying, cooling and refreshing; the noxious odors which so easily accumulate under dense bed clothes have then no abiding place; and the febrile heat is dispersed instead of being retained as an addition to the evil that already exists.

The mistake now so generally made lies in the idea that the warmth which the bed calls for is best obtained by close material and close packing. The error is positive. There is nothing that retains warmth in so good and equable a manner as common air at rest. Dense materials, as Count Rumford demonstrated, cannot keep the body respirably warm. If they are nonconductors they may retain the heat, but then they retain also the cutaneous transpiration; whilst air, a splendid nonconductor, permits the freest diffusion of cutaneous emanations. Materials, therefore, both for the bed and for the bed-clothing, ought to be porous to a free mechanical extent of porosity. The rule holds good for the clothing of the body in health; in sickness it is imperative.—*Asclepiad.*

Treatment of Gonorrhœa.—Professor Reverdin, of Geneva, gives the following: He found that permanganate of potassium was the best thing to use, but the method of doing it is important. (One to five thousand solutions are used.) Each patient has his own sound, and a glass fountain-syringe is hung above his head. He is directed to stand, and a rubber or mackintosh apron, with a hole in it, protects his clothing from splashing of the injection. He is instructed to urinate, and then pass the organ through the opening, and the sound is put into the penis without being lubricated. The liquid is then allowed to flow, as much as a quart and a half being used, twice a day. The sound is kept in the anterior urethra. The treatment lasts two weeks and amelioration is very rapid. No liquid gets into the bladder and no orchitis follows the cure.—*Med. Fortnightly.*

The Yellow Above the Black.—In a *Question of Diplomacy*, a short story by Dr. Conan Doyle, the Prime Minister and another minister of Great Britain have a conference in the sick-room of the latter, who is laid up with the gout. Says the sick man: "My head is clouded; sometimes I think it is the gout, and sometimes I put it down to the colchicum." "What will Sir William say to that? (Sir William is the physician in the case). You are so irreverent. With a bishop you may feel at your ease—bishops are not beyond the reach of argument. But a doctor, with his stethoscope and thermometer, is a thing apart. Your reading does not impinge upon him. He is serenely above you. And then, of course, he takes you at a disadvantage. With health and strength one might cope with him. The time for argument has passed when the doctor is in the house—then is the time for obedience, if not contrition."—*N. Y. Med. Jour.*

Diet of Nervous Patients.—Dr. E. C. Mann, *N. Y. Med. Times*, writes as follows:

In the diet list of our patients we pay especial attention to the relative value of foods and the physiological laws governing their use. We aim by a careful regulation of the diet to supply to the body heat, energy, lubrication, rotundity of form and elements for glandular, muscular and all tissue construction, and such compounds containing sulphur as fulfill the office of ferments.

We aim to have ingested into the body such material which, when brought under the influence of oxidation, will yield energy, which is the expression of vital activity. We want the largest working power for the amount of food taken. We also pay great attention to proper cooking, so that the food may be presented in an easily digestible form. The carbohydrates are supplied in nearly the requisite quantity by the natural fats of the proteid food stuffs and the small amount of vegetables allowed in our diet list. I exclude vegetables largely in my dietary computation, for the reason that their use requires an enormous outlay of oxygen, and thus necessitates the formation and handling by the glandular organism of the body of an excessive amount of incomplete nitrogenous excrementitious elements. I aim to get by food great concentration of energy, physical ability and mental activity, and, as I have said, get for the body heat, energy, rotundity of form, elements for anabolic processes and important coustituents for the ferments, and to limit the amount of food ingested daily to a degree where, other things being normal, no products of incomplete metabolism will appear in the urine. The oxidation of the proteids and their combined fats, plus a minimum quantity of cereals, supply all the energy needed per diem. In this manner my patients, who I make proteid feeders, can withstand disease better, are capable of greater concentration of energy and mental activity, and, after leaving my sanitarium, live a longer and more successful existence than those in some other institutions where diet receives little or no attention. My diet table, therefore, is made up principally of the meats, milk, oysters, fish of all kinds, including the crustaceæ and molluscæ, eggs, cheese and all allied substances as the principal diet, while potatoes, bread, beans, oatmeal, peas and rice are allowed to be eaten sparingly. We rely, therefore, on a diet which requires the least vital force and oxygen to digest, assimilate and appropriate it, and we claim to get much quicker and more lasting recoveries in the field of diseases of the nervous system by the careful regulation of the diet, combined, of course, with an appropriate therapeutic treatment, than we could without it.

Gonorrhœal Pyæmia.—*The Practitioner* contains an account of a fatal case of pyæmia from gonorrhœa. The victim, a youth of nineteen, had a

urethal discharge in February, which readily yielded to rest in bed and sublimate irrigation. Toward the end of March, he was exposed to severe cold and great exertion, and on the following day had a chill. Four days later he showed numerous reddish spots on face, arms and trunk, which proved to be hæmorrhages. The heart was enlarged, and a blowing systolic murmur was heard over the apex; the spleen reached to the costal margin. Pulse, 104; temperature 104.8°; urine normal. Blood normal. Deafness came on two days later. In less than three weeks from the onset, the patient had diarrhœa, marked thirst, a remittent high temperature, and was becoming dull and apathetic. A week later more spots appeared, and heart had still further increased in size.

Œdema of the legs soon set in, the spleen became palpable, and the patient died suddenly.

At *post-mortem* œdema of the lungs, ecchymosis of the pleura, and minute hæmorrhages beneath the endo, and pericardium were found. Ulcerative endocarditis of the aortic valve, and a puriform softened thrombus at the apex of the heart. Infarcts were discovered in one kidney and in the spleen. In the vegetation of the valve, numerous cocci were found, of the form and size of the gonococci, and showing its staining reaction to Gram's method. None were found in infarcts.—*Clinique*

Wit and Humor.

He Hadn't Taken Anything.—"Have you taken anything for your influenza?" asked the doctor of a long, lank, hungry-looking man, who came to him complaining of being "all run down," his appearance verifying his words.

"Well, I ain't been takin' much of anything, doctor—that is nothing to speak of. I tuk a couple o' bottles o' Pinkham's bitters awhile back, an' a bottle o' Quackham's Invigorator, with a couple o' boxes o' Curem's pills, and a lot o' quinine and root bitters my old woman made up. I've got a porous plaster on my back an' a liver pad on, an' I'm wearing an electric belt an' takin' quinine and iron four times a day, with a dose or two of salts ev'ry other day. 'Ceptin' for that, I ain't takin' nothin'."—*Ex.*

A Tale of Two Cities.—Mr. Gotham. "Ha, ha, ha! That's good! The paper says a man in Philadelphia was run over by a funeral procession. Ho, ho, ho, such a thing couldn't happen outside of slow old Philadelphia." Mr. Broadbrim—"A similar accident has happened in New York only recently." Mr. Gotham—"Impossible." Mr. Broadbrim—"It was at a rich man's funeral and the relatives were going back to the house to hear the will read."—*New York Weekly.*

Man, born of woman, is of few days and no teeth. And indeed it would be money in his pocket sometimes if he had less of either. As for his days, he wasteth one-third of them. And as for his teeth, he has convulsions when he cuts them. And as the last one comes through, lo! the dentist is twirling the first one out; and the last end of that man's jaw is worse than the first, being full of porcelain and a roof-plate built to hold blackberry seeds.—*Burdette.*

"THE SUM OF LIFE."

BY BEN KING.

Nothing to do but work,
Nothing to eat but food,
Nothing to wear but clothes
To keep one from going nude.

Nothing to breathe but air;
Quick as a flash 'tis gone;
Nowhere to fall but off,
Nowhere to stand but on.

Nothing to comb but hair,
Nowhere to sleep but in bed,
Nothing to weep but tears,
Nothing to bury but dead.

Nothing to sing but songs,
Ah, well, alas! alack!
Nowhere to go but out,
Nowhere to come but back.

Nothing to see but sights,
Nothing to quench but thirst,
Nothing to have but what we've got;
Thus thro' life we are cursed.

Nothing to strike but a gait;
Everything moves that goes.
Nothing at all but common sense
Can ever withstand these woes.

—*Chicago Mail.*

A Slur Refuted.

A number of years ago, David Baker, a one time famous poet of the State of Maine, on the birth of his first child, wrote the following little gem:

One night as old St. Peter slept
He left the door of Heaven ajar,
When through a little angel crept,
And came down with a falling star.

One morning as the blessed beams
Of sun arose, my blushing bride
Awakened from some pleasing dream,
And found that angel by her side.

God grant but this, I ask no more,
That when he leaves this world of pain,
He'll wing his way to that bright shore,
And find the road to Heaven again.

John G. Saxe, not to be outdone, and deeming that an injustice had been done to old St. Peter, wrote the following as St Peter's reply:

Full eighteen hundred years or more,
I've kept my gate securely fast;
There has no little angel strayed,
Or recreant through that portal passed.

I did not sleep as you supposed,
Nor left the door of Heaven ajar;
There has no little angel strayed,
Nor gone down with a falling star.

Go ask that blushing bride and see,
If she don't frankly own and say,
That when she found that angel babe,
She found it in the good old way.

God grant but this, I ask no more,
That should your numbers still enlarge,
You will not do as done before,
And lay it to old Peter's charge.

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

VOL. XV. MARCH, 1893. No. 3.

ORIGINAL ARTICLES.

Transplanting of Intestine—A New Method of Treating Nonmalignant Strictures of the Rectum.

BY JOSEPH B. BACON, M. D.

Professor of Rectal Surgery in the Post-Graduate Medical School, Surgeon to the Chicago Charity Hospital, Columbia Dispensary, and the Hazeltine Home, Fellow of the Academy of Medicine.

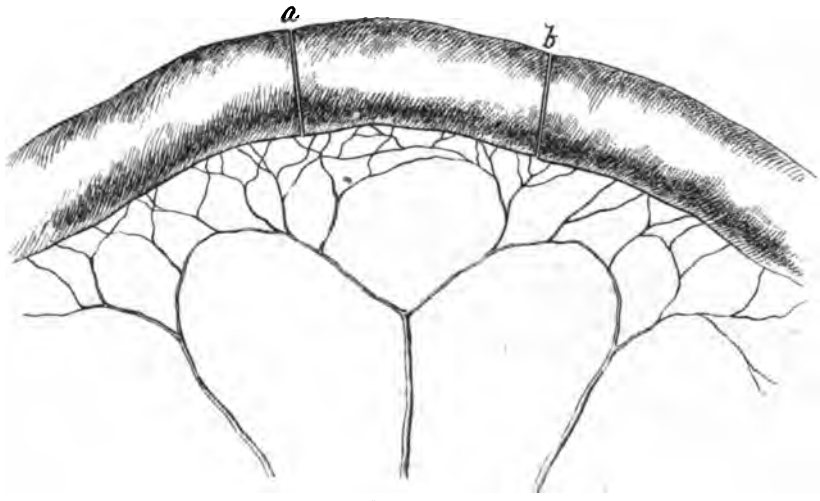
I have been experimenting upon dogs with a view of devising a plan to overcome rectal strictures that would enable the surgeon to take advantage of the modern aseptic methods of operating. The brilliant results of abdominal surgeons have demonstrated that laparotomies can be done with a minimum risk. We know that with the Trendelenburg position the whole of the rectum above the levator ani is accessible for operating, where but few sutures are required. The recent mechanical devices that have been invented for intestinal anastomosis, especially the Murphy button, make operations possible that were previously impracticable on account of the time required for suturing, and the dangers of fecal fistulæ and sepsis resulting from the sutures giving way. Experiments upon animals by such thorough investigators as Senn, Robinson, and Murphy, show that lateral or end to end anastomosis of the small intestine is practicable, safe, and can be followed by permanent and good results. Robinson demonstrated that a piece of gut, after having been entirely severed from the intestinal tract, although left filled with feces, and its ends invaginated, would live and produce no inconvenience to the dog, if the mesentery supplying the severed piece was carefully preserved. He let these dogs live for weeks and they completely recovered from the operation, gained in flesh, were playful, and showed no unfavorable symptoms from the experiment.

Senn anastomosed the ilium into the rectum and also the colon to the rectum successfully. He claimed as a result that if stricture of the sigmoid was to be overcome his operation would be preferable to an artificial anus, if the opening where the anastomosis was made did not with time contract too much.

Murphy demonstrated that by using his button anastomosis of the intestine could be made, either end to end or lateral, in a few minutes. I have confirmed this by experiments many times since his report.

The operation of transplanting of intestine consists in completely severing a portion of a loop of small intestine, that is lying in proximity to the rectum, and anastomosing each end with the rectum so as to form a new channel around the stricture. The mesentery of the severed piece of gut is left intact. A piece of intestine is selected from the loop at a point where the mesenteric blood vessels supply a large nutrient artery for each end of the piece to be transplanted.

It is necessary to remember in cutting out a piece for transplanting that it must be long enough to extend from a point below the stricture to a point above the stricture, where the rectal wall is not too much thinned by ulceration, and also to remember that the button to be inserted into each end will shorten the piece about one and a half inches.



No 1.

PLATE No. 1—Loop of the ilium illustrating how to select a piece for transplanting, so as to have its mesentary supplied with a large artery.

The operation is completed by scarifying the approximated surfaces of the rectum and transplanted piece of gut and suturing them together so as to have the two walls cemented into one firm septum. At a subsequent operation this septum is removed by compression forceps, and the lumen of the rectum and transplanted piece is made into one cavity, and the sloughing out of the compression forceps will destroy one-half of the stricture, together with the septum, thus putting an end to the contraction of the cicatricial tissue forming the stricture.

The mesentery and transplanted piece of gut is sutured in close approximation to the parietal wall to prevent the possibility of a loop of intestine sliding under it and becoming strangulated. A Murphy button is now used to make end to end anastomosis of the gut, from which the transplanted piece was resected and its mesentery sutured carefully so as to leave no opening for hernia to occur. Through the kindness of Prof. Tanquery I was permitted to examine the viscera of fifteen bodies in the dissecting room of the College of Physicians and Surgeons of this city. In all but one of them I was enabled to pull down the sigmoid to the bottom of the Douglas cul-de sac, or recto-vesical pouch. This demonstrated to me the possibility of using a modified transplanting opera-

tion in many cases, viz., pull the sigmoid down below the stricture in the rectum, and with a Murphy button anostomose it with the rectum. Scarify the approximated surfaces of the sigmoid and rectum and suture them together to get a firmly united septum, as in the complete transplanting operation. Subsequently a part of the whole of this septum is removed by compression forceps, thus one-half of the stricture is destroyed and the lumen of the rectum increased. The female half of the button to be used below the stricture, must be inserted by an assistant into the rectum through the anus. By this means the operator can by feeling deep down in the pelvis from above instruct the assistant just where to press the staff of the button against the rectal wall, and the incision made directly over the end of the staff will need to be so small that the staff will snugly fill the opening, and thus no sutures will be required for this half of the button. This is a very important point, as suturing in this deep part of the pelvis will be all but impossible. By this means of introducing the lower button the possibility of fecal infection while placing the button is prevented.

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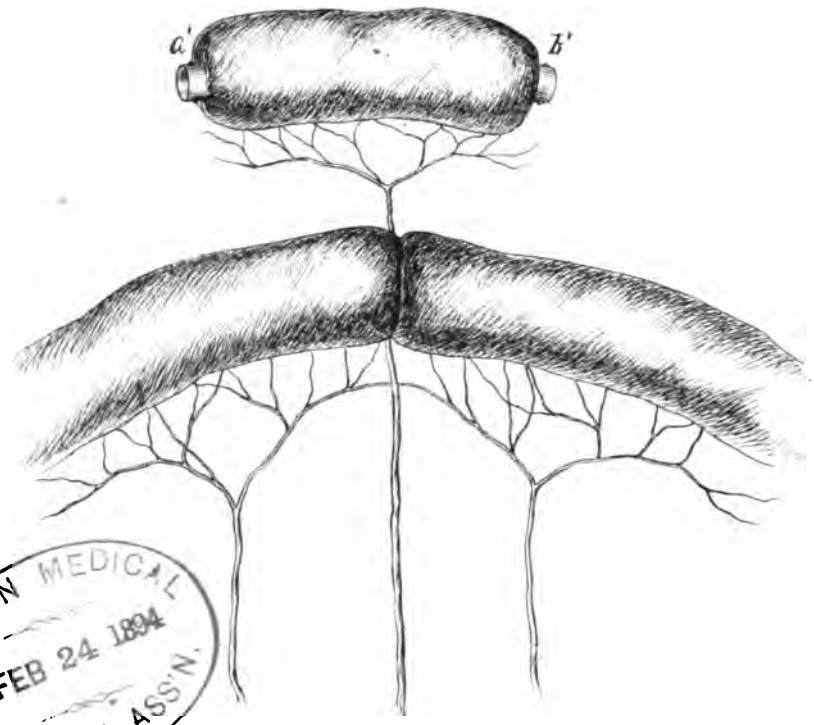
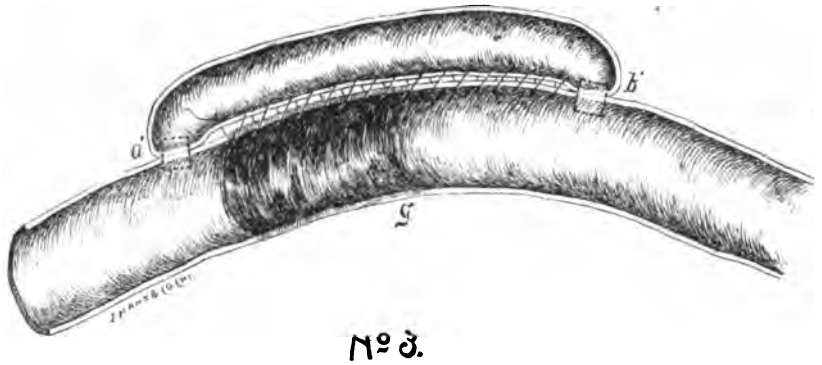


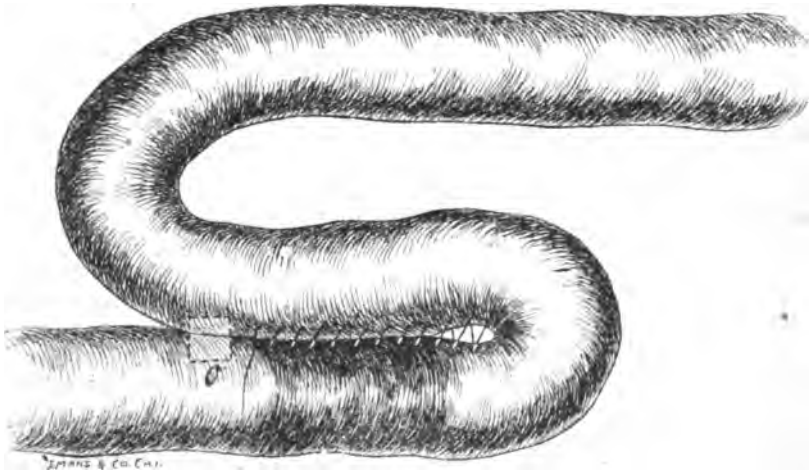
№ 2.

PLATE No. 2—Appearance of the piece of gut for transplanting with the male half of button in each end. End to end approximation.



№ 3.

PLATE No. 3—Transplanted piece in position with anastomosis above and below the stricture. (Sutures must only penetrate the peritoneal covering of the bowels.)



№ 4.

PLATE No 4—Anastomosing of the sigmoid and rectum below the stricture and suturing the surfaces to form a septum.

The advantages of transplanting intestine for the cure of rectal strictures are:

1. It is more conservative than excising the stricture by the old methods.

2. There cannot be a resulting incontinence of fæces.

3. It enables one to open the peritoneal cavity by a clean, aseptic operation, without the dangers of fecal infection and giving away of dangerous sutures.

4. No other method insures a permanent cure, even if the patient survives the operation.

NONPROTECTIVE POWER OF DRUGS.—As the result of an extended series of experiments upon animals, Dr Brunton and Dr. Bokenham have arrived at the conclusion that saturation of the system with salts of potassium, magnesium, calcium, strontium and aluminium afford no protective power against disease, although they claim no bad effects resulted from the long continued administration of these drugs in large dosage.

Surgical Aspect of Acute Intestinal Obstruction.*

By John I. Skelly, M. D.

It is not the purpose of this paper to enter into the ætiology and pathology of intestinal obstruction, nor do I expect to cover the whole field of intestinal surgery. These important matters have been thoroughly treated by those who are competent, and any good text-book on surgery will be found to cover the entire subject. I desire simply to refer to my own personal experience in acute obstruction, and to offer a plea for a do something, instead of a do nothing, plan of treatment.

Until recently the method of treatment adopted by many practitioners has been the so-called expectant starvation, rest, opium, belladonna, etc. Others have endeavored to overcome the obstruction by the use of powerful purgatives; croton oil, quicksilver, and even shot have been vainly prescribed for this purpose; doing much harm, and probably no good. Distension of the intestine by injection of fluids, or inflation with air or hydrogen gas has been reputed successful in some cases of intussusception, and might be tried before resorting to laparotomy. The hydrogen gas may determine whether there is an obstruction, but I should fear to rely upon it to cure. True a case may occasionally recover, but in such case we do not know the nature of the obstruction nor do we know that rational surgery would not have been better for the patient, as it is less likely to be followed by recurrence.

The dread of the knife on the part of the patient, and the fear of entering the abdominal cavity on the part of the surgeon (until recently), have kept us from advancing, and cost many valuable lives that might have been saved by a timely resort to laparotomy. The first operation for intestinal obstruction that I have been able to find any account of was by Ramdohr in 1727 when he resected a portion of intestine for strangulated hernia. This was 165 years ago and we are just now beginning to profit by his success. Strange, how slowly the light of truth dawns upon us! It is so not only in medicine and surgery, but in all other sciences, and so it will continue to the end of time. We have been afraid of going to extremes, but the subject of this paper is one in which we are not likely to do that; we are more likely to sin by omission than commission.

My experience embraces twenty cases, extending over nearly a quarter of a century, and as I am compelled to rely upon memory I cannot give details in each case. Three were due to impaction of feces in sigmoid flexture, and did not require any cutting operation. The impaction was broken up and the fecal matter expelled. All of these cases recovered. Of the other seventeen cases, fifteen died. Four of them were operated upon, and two recovered. The two that died were in my opinion more favorable cases for successful operation than the second that recovered, but the operation was delayed in each case about one week, and the intestines were found in a gangrenous condition. The first successful case was a lad nine or ten years of age. The obstruction was in the ileum, at the ileo-cæcal junction. There was a prominent tumor, as large as a fœtal head, which was quite movable laterally, but scarcely so in any other direction. There was a circumscribed peritonitis which had united the peritoneum to the ileum, and also to the overlying abdominal parieties. Luckily it was so. That saved the boy. The attending physician thought it was an abscess, and I was called to open it. There was considerable fluctuation, but the bulk of the tumor was quite solid. I made an incision perhaps two inches in length, with a view of determining the nature of the obstruction. A quantity of fluid fœcal matter followed the knife and then the wound was blocked up by a more solid substance, which upon investigation proved to be the woody fiber of young hickory roots which the boy had eaten. A great quantity of this was removed and the tumor and obstruction disappeared. We were very much alarmed over this case for it was then considered an unpardonable sin to cut a gut. The wound was carefully closed, the edges brought into exact apposition, and contrary to our expectation the lad recovered without an unfavorable symptom. The second successful operation was for the relief of strangulation. The hernia, right inguinal, had been reduced by patient as had been done many times before. This time his suffering was intense, and he readily consented to operation. The operation was done within twenty-four hours. After reduction, the constriction which was the neck of the sac was cut, and the patient had no further trouble, nor has there ever been a recurrence of the hernia so far as I know.

The first fatal case was almost identical with the last success. A strangulated hernia reduced by patient as was his custom. Of course this was the first time strangulation ensued. Saw patient three hours after he had reduced the hernia, right inguinal. He was suffering intensely, pain in right inguinal region. Did what I could to relieve him and left with understanding that an operation would be advisable if he was no better by morning. He was worse next morning and counsel was called; counsel advised waiting, and the operation was put off from day to day for seven days. Patient insisted that an operation be done to relieve him of his great suffering. He did not hope for cure. Abdominal cavity was found full of bloody serum. Serous coat of intestine dark, and so broken down that it rubbed off at slightest touch. Constriction readily found and cut. Patient lived thirty-six hours, free from pain, and died of exhaustion.

The second fatal case was operated upon recently, one week after the attending physician was called to the case. A double volvulus was found in jejunum as we supposed. Condition of intestine much the same as in the other fatal case, perhaps not quite so bad. Patient lived three days after operation and died of exhaustion. In both fatal cases the bowels were patent after operation. In referring to this obstruction as volvulus I mean a twisting of the gut on its long axis. Our text-books tell us that this seldom occurs except in the sigmoid flexture. This case then is an exception for the twists were in the small intestine. There were two of them, about eighteen inches apart, and I plainly felt the fluid contents of the intestine rushing through it as I untwisted the obstruction. I see no reason why both these patients might not have been saved by timely operation. Of the remaining thirteen cases but one was examined postmortem. A knuckle of intestine had slipped through a rent in the omentum and become constricted. The

*Read before the Military Tract Medical Association, Canton, Ill., Oct. 17th and 18th, 1892.

woman had recently been delivered after a hard labor, and her attending physician thought that had something to do with it. Three other cases of reduced strangulated hernia refused operation and died

There yet remains nine cases unaccounted for as to the nature of obstruction, no operation nor post-mortem being had. In nearly all of the seventeen cases the earliest and most prominent symptom was localized pain, and in the four cases operated upon, as also the post-mortem, the obstruction was found in the part of the abdomen where the patient complained of the pain and I have reason to regard this as a valuable symptom of which our text books take little account. Stercoraceous vomiting which has always been regarded as pathognomonic, does not always occur, and the loss of my first case I attribute to waiting for this sign as was insisted upon by my consultants. I appreciate that it is often a very difficult matter to decide what is best to do in acute intestinal obstruction. Some of our text-books might lead us to think it easy to diagnose the character of the obstruction, but in actual practice we soon discover that it is very difficult if not impossible to locate the injury and determine its exact nature. The chances for recovery by the expectant plan of treatment are very slim indeed. In these days of antiseptic surgery we need have no fears of laparotomy; it will do no harm: by it we may determine the condition of our patient, and that condition will reveal to us our duty. We cannot tell what kind of operation may be necessary upon the intestines until we see them, but if we only act in time, success will generally crown our efforts. I have no desire to appear heroic nor advise harsh measures, but rather to offer to suffering humanity the best service that our science can offer, and thereby add to the sum total of human life and human happiness.

Eye Strain.*

By R. E. Lewis, M. D., Macomb, Ill.

A question propounded to us almost daily is, "Why do so many children wear glasses?" Do the eyes of children to-day differ from those of many years ago; are they of different structure; do rays of light in passing through them focus differently, or must we look to changes of surroundings and occupations for our answer?

Surely the anatomy of the eye remains the same; so also do the laws of refraction governing it, but as for influences brought to bear from without we cannot say so much, as these have been year by year undergoing gradual change.

Children read more than was customary years ago, and defects in refraction which then would have been carried through life without particular notice, now that the accommodation is called more constantly into use, make themselves known and demand attention. Also, children of to day reach much higher grades in school than those of twenty years back, and with this advance goes the necessary labor to attain it, throwing a great amount of work upon the eyes.

It is a common thing for us to see little ones ranging from eight to fifteen years carrying great armfuls of books home to study at night; one of the most trying tasks the eye is subjected to, especially when only about twenty per cent of families have their homes properly lighted for study purposes. When the light is poor it is natural for the reader to hold the book or paper near to the eyes to enlarge the images and make them clearer. Now there are three things in the eye which necessarily go together, viz.: Convergence, contraction of the pupil, and the act of accommodation. Holding the book near the face brings about convergence and according to the above law the other two must follow.

If this work in defective light be continued for any length of time the ciliary muscle governing accommodation becomes tired and shows its inability to keep up the strain and the reader finds it necessary to lay aside the work and relax the accommodation long enough to give it rest. This line of work persisted in for weeks or months permanently weakens the muscle and it fails to respond, when called upon to act, sufficiently strong to make clear the image of objects looked at. It is here that the whole train of symptoms manifested by persons, the subject of eye strain, is exposed, and the sufferer seeks advise either from the family physician or specialist or it may be gives up work thinking his condition due to declining health. The symptoms manifested in such cases are varied, and differ somewhat in severity according to the amount of defect and the variety of refracted error present.

Often there is an indistinctness present after continued work and associated with this, the complaint of the words and letters running together, and a tired heavy feeling in and about the eyeball itself. The pain felt is usually in the head and localizes itself in the temporal or frontal regions, as a rule, but may be occipital. Not unfrequently, too, we find pains shooting down the sides of the nose. All these are more or less constant, depending largely upon the persistence with which the eyes are used for near work. Floating specks and cobwebs are many times seen on the reader's page and in persons of a nervous temperament become very annoying, but are harmless as long as they appear outside the eye and are usually promptly removed by the adjustment of suitable glasses. Blepharitis marginalis is another common indication and should always make the physician suspects eye strain.

Myopes generally complain of nothing but dimness of vision except when astigmatism is present; while hypermetropes are greatly annoyed by a small defect and the more so when combined with astigmatism. Some hypermetropes will tell you that they can see as well as any one and on examination you find that they can read beyond normal type. This is possible only by spasm of the accommodation which lasts but a few moments and cannot be brought about again until the eyes have taken rest. It is in such cases that our mydriatics are of so much service to us and where glasses so promptly relieve the distressing head symptoms.

Astigmatism causes more discomfort than either myopia or hypermetropia alone, and should be corrected no matter how small the degree. I have selected two or three cases from my notebook which may assist to illustrate.

Case I.—Dr. L., a dentist, complained of frequent attacks of sick headache, which had gradually been coming nearer together and growing more severe. Sometimes they would last for two or three days and would not yield to anodynes. His eyes were examined and the following glasses prescribed:

*Read before the Military Tract Medical Association, Canton, Ill., October 17th and 18th, 1892.

O. D.—.75 D. cyl. ax. 180°.
O. S.—.62 D. cyl. ax. 180°.

The glasses were adjusted during an attack and relieved the headache almost instantly. There is no return of the symptoms as long as the glasses are worn, but on leaving them off they appear with all their former severity.

CASE II. is an interesting one, partly on account of the slight degree of defect present, and partly because of the deviation of the axis of the cylinder from that customarily found.

L. P., a school boy ten years old, complained for more than a year of headache in the temporal and occipital regions, and was given all manner of headache cures, tonics, etc., which had been recommended not only by the neighbors, but also by the family physician, none of which gave any relief. The following glasses were prescribed.

O. D.—.25 D. cyl. ax. 130°.
O. S.—.25 D. cyl. ax. 70°.

With the result that the vision was brought up to normal in each eye, and complete relief from all the head troubles obtained.

CASE III.—Miss F., age nineteen, a student, complained of headache, quite severe at times, and the appearance of a cloud before the eyes after working closely at her books for a time. She also complained of vertigo when entering a crowd or public meeting. For her were prescribed:

O. D. + .50 D. S. ⊃ + .50 D. cyl. ax. 45°.
O. S. + .50 D. S. ⊃ + .50 D. cyl. ax. 90°.

They were worn when the eyes were used for near work, and at public gatherings, with perfect ease, and gave complete relief.

To be sure three cases are not enough to prove any subject, but they are only so many of any number which any specialist can furnish to show that the subject of this paper is one of the most potent in the production of head troubles. It is a cause which until recently has been overlooked, and has given the general practitioner no little trouble for he has given antipyretics, cholagogues, tonics, etc., time and again only to have so many failures. Now that he recognizes these troubles he makes many a short cut, and through his advice brings relief to his suffering patient, where if he should fail to detect the trouble, he might not only lose the confidence of those seeking his assistance, but also be the subject of sharp criticism. Every physician would find it of great benefit if he had a set of test type and astigmatic cards in his office; the former for diagnosing the greater degrees of myopia and hypermetropia, and the latter for detecting astigmatism, the most productive of headache.

That part of opthalmology, which has to do with fitting glasses, is a science, and should not be allowed to leave the scientific world, as it too often is, when we see men peddling glasses through the country for a living. The chief aim of such men is to make a sale, while it should be to make an accurate fit, and give satisfaction. More harm is often done by the improper adjustment of glasses than would come if the defects in vision were left uncorrected. We should instruct our patients in this regard, and when we have educated them up to a proper appreciation of this fact, we have returned the science to its stand of elevation and done a commendable work for our fellow men.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

The Suggested Change in the Commitment of the Insane.

The suggestion by the Medico-Legal Society that the jury trial of lunatics be abolished, and a medical board of examination appointed whose decision shall be final, arouses the ire of the daily papers. One of these self-appointed regulators of the universe declares the tribunal would be composed of parnoiacs and men of low morals who would be for sale to the highest bidder, and adds that the lay world divides insanity experts into these two classes. The bright young man who wrote this imagined that he had closed the whole subject by writing himself down Dogberry fashion as the sharer of the opinion usually held. Trial by jury has caused more than one unfortunate lunatic to go to an asylum possessed with the idea that he had been convicted of crime after a formal trial.

Because some insanity experts are extremists and some who pose as such will try to make out a case for the side which employs them are not sufficient grounds for a wholesale condemnation of the men who have devoted their lives to the study of the most deplorable of human afflictions. There is no class or profession so pure that venal men cannot be found in it. It is presupposed that the men occupying positions on such a commission would be of attainments and morals too high to be mentally unsound or purchasable.

That an editorial writer who has probably never seen a lunatic, except at long range, should assume a greater knowledge of their needs than any one else is not surprising, for he earns his money by his air of authority, but that he should make this suggestion a ground for attacking a large class of eminent men is unpardonable and wholly without reason.

Electrical Quacks and the World's Fair.

The action of the superintendent of the electrical department of the World's Columbian Exposition in excluding the quack electrician with his array of belts, shields, pads, etc., will meet the hearty approval of all fair-minded men and will arouse the gratitude of physicians in particular. The profession has seen the preference given to frauds of this ilk so long and often that the attitude of the World's Fair people will cause nearly as much surprise as pleasure.

Dr. Frank C. Hoyt, founder of the *Medical Herald*, St. Joseph, Mo., and for years pathologist and assistant physician to the Missouri Asylum, No. 2, has been appointed superintendent of the Insane Asylum at Clarinda, Iowa.

The New Superintendent of the Kankakee Asylum.

Dr. S. V. Clevenger's appointment as Superintendent of the Asylum for the Insane, at Kankakee, insures that institution an administration which will give the greatest benefit to its inmates, and contribute most largely to the advancement of the science of neurology. Dr. Clevenger is able, original, painstaking and energetic. Eminent in his specialty, he needed only an opportunity commensurate with his ability to make his influence strongly felt.

Portraits of Eminent Men.

Beginning with this issue the WESTERN MEDICAL REPORTER will publish monthly a half tone portrait and biography of some physician who has made an impression on medical science and who is still doing good work in his chosen field. The portraits will be executed in the highest style of the engravers' art. Their appearance will add another feature of interest to this complete "epitome of practical medicine."

Dr. Harold N. Moyer.

The subject of this short biographical sketch was born in the State of New York, August 14, 1858, and is therefore 34 years of age. Few men indeed have so rapidly risen in the confidence and esteem of their chosen profession as has Dr. Moyer. Beginning with every advantage as regard his preliminary education and the means to secure every advantage of foreign study and travel, Dr. Moyer improved his opportunities as few students do. After graduating at Rush Medical College Dr. Moyer spent much time abroad in the study of neurology—his special predilection. He was for some time one of the favorite pupils of the celebrated Erb, of Heidelberg, and even to-day suggests in his systematic and painstaking work, the methods of his celebrated master.

Dr. Harold N. Moyer.

Dr. Moyer justly ranks as one of Chicago's ablest teachers and clinicians, and in his special line of research is certainly in the foremost rank. This is much to say, for Chicago stands second to no medical center in this country in the attainments of her neurologists. Dr. Moyer has occupied some very prominent professional positions, having been on the staff of the Kankakee Insane Asylum and Cook County Hospital. He has recently been appointed neurologist to the latter institution and to the detention hospital for the insane. He served also as county physician for several years. Perhaps the most prominent position which Dr. Moyer has held, was the professorship of physiology in Rush Medical College. He has recently been promoted to a practical chair, and is now adjunct professor of medicine in that excellent institution.

Personally Dr. Moyer is one of the most popular men in the profession; his friends are legion, his enemies an unknown quantity. Built upon a broad gauge and liberal plan, Dr. Moyer is one of the men whom it is well to know. As he is talented, there is no one who can preside at the festive board where doctors—alas! too rarely—do sometimes congregate with the grace and *savoir faire* possessed by Dr. Moyer. The doctor has, however, one fault for which his lady friends are loath to forgive him; he is a confirmed old bachelor, who will never get married because he is too good natured and the world has no dark places for him, that matrimony might brighten. And when the ladies sorrow thereat, we cannot say "there's just as good fish in the sea," for we must confess that there are none.

ABSTRACTS.

Medicine.

TREATMENT OF DYSPEPSIA IN CHLOROSIS.—Professor Potain calls our attention to the fact that dyspepsia is very common in chlorosis, and that it can keep the latter disease going, no matter what the treatment of the dyspeptic symptoms. The division of the alimentary substances is the most important matter, for these patients will swallow quickly anything that is given to them, because they do not care for food and wish to get rid of it as soon as possible, with the result that the dyspepsia increases. Meat is recommended to be crushed in a mortar and passed through a sieve. This will prevent danger of worms, also, as it destroys the eggs. The meat pulp is then best given mixed in soup. A point here is that the soup is not used too hot, for the meat will curdle in it and not dissolve. It may also be mixed with mashed vegetables and slightly cooked. These patients are always thirsty, and should be cautioned not to drink large quantities of liquids at once. As they are often constipated, the best iron preparation to give is the tartrate of iron and potash. In fact, hygienic treatment is the best in these cases; life in the open air, while iron mineral waters are not to be neglected. — *Med. Herald.*

MURMURS HEARD IN THE NECK.—In view of the great difference of opinion amongst authors and teachers as to the diagnostic significance of the venous and arterial murmurs in the neck, Dr. James K. Crook's conclusions, after an examination of fifteen

hundred persons, are of more than ordinary interest. He concludes as follows:

Conclusions: The important deductions from the foregoing statistical study of these vascular phenomena may be briefly summarized as follows:

1. Hæmic bruits are rarely heard in healthy persons.

2. They are not often heard in persons not showing a considerable degree of anæmia.

3. They are heard in 90 per cent of persons showing a well-marked degree of anæmia.

4. They are, therefore, of great significance in the diagnosis of this condition.—*American Journal of the Medical Sciences.*

A Case of Chorea and Rheumatism.—Dr. W. B. Thistle, *Canad. Practitioner*, reports the following interesting case: The patient, a well-developed girl of about fourteen, was admitted to the Victoria Hospital suffering from pronounced chorea. Until about a week previous to admission she had been in robust health. At that time she complained of pain and tenderness in wrists, followed shortly by involuntary movements. At the present time both wrists and ankles are swollen, red and tender. She has elevation of temperature, and there is an erythematous rash on the face; no heart murmur is audible. The choreic movements are almost constant, and so violent and extreme as to prevent her walking or feeding herself. Precautions were necessary to prevent her falling out of the bed. She was ordered to be kept in bed, and as free from worry and excitement as possible; liq. arsenicalis, beginning with *m* vii. dose, to be given three times a day, the arsenic to be increased *m* i. every second day. In addition, she was put upon a mixture of soda salicyl. and the acetate of potash, grs. xv. of each every four hours. The bowels were freely moved by calomel. In order to procure sleep, and, as a result, cessation of movement, sulphonal, grs. xx., to be given in hot milk one hour before bedtime. Improvement began at once. On the second night she slept five hours naturally, the next seven hours, and from that time the usual amount of sleep was obtained. Salicylate mixture was discontinued at the end of a week, the joint symptoms having disappeared. Three weeks from date of admission patient was almost well, slight movement only remaining. It would seem that the action of the rheumatic poison on the nerve cells is in these cases sufficiently irritating to interfere with their function and bring about the chorea. To eliminate, and as far as possible counteract, the poison in every case in which there is or has been evidence of its presence would seem to meet the indication in the way of preliminary treatment.

Treatment of Pneumonia.—In relation to the treatment of pneumonia, Dr. Boardman Reed has expressed his views as follows:

1. Water locally applied, either by wet packs or in the form of baths, after the Brand method, is the most efficient single remedy or therapeutic measure for acute pneumonia.

2. Either veratrum viride or aconite can accomplish more than any other single drug in the first stage, and that the same is true of digitalis in the second stage.

3. A combination of one of these cardiac sedatives with opium and diaphoretics, affords not only a safe but an eminently successful internal treatment for the first stage of acute pneumonia, being capable of aborting the disease when its administration is begun near the onset, and is repeated at short intervals day and night.

4. Venesection, though a most efficient means of treating sthenic forms of pneumonia, and, judiciously employed, considerably more successful than any merely expectant method, is no longer an indispensable resource in managing the disease, since other remedies have been found to accomplish the same results more surely and pleasantly.—*Therap. Gazette.*

Treatment of Typhoid Fever by Systematic Cold Bathing.—Prof. J. C. Wilson, in a late issue of the *Medical News*, describes the treatment of typhoid fever after the method of Brand, and gives a further report of the results obtained by this method in the German Hospital, Philadelphia. The method consists in the following systematic procedure. Whenever the temperature, taken in the rectum, reaches 102.2 degrees F. (39 degrees C.), the patient is placed in a bath of 65 degrees F. A compress wet with water about five degrees lower, is placed on the head, or water at a lower temperature is poured upon the head and shoulders. The patient remains in the bath fifteen minutes, during which time he is systematically rubbed by the attendants, and encouraged to rub himself. At the expiration of that time he is removed from the bath, and wrapped in a coarse linen sheet, over which a blanket is folded, the extremities being thoroughly dried and rubbed. A little wine or spirits is then given. This is repeated every three hours, unless the temperature remains below 102.2 deg. F. The alimentation is liquid, nutritious, and carefully regulated. No drugs are administered.

The total number of cases treated by this method was 226; the total deaths 12 or 5.3 per cent. Relapses occurred in nineteen instances; more than one relapse occurred in two cases. This method of treatment has reduced the death rate in this institution nearly 50 per cent from the best showing of previous years, and 66 per cent from the most favorable statistics of the hospitals of the city under other methods. —*Medical Summary.*

Treatment of Asthmatic Attacks.—Dr. Dieulafoy, in *Merck's Bulletin*, says when an attack of asthma begins, the nasal fossæ should *immediately* be painted as far upward in their interior as possible with a pencil soaked in a solution of cocaine hydrochlorate (1 part in weight to 20 of water). Or, better still, spray the nose or the pharynx with this solution for 4 to 5 minutes. This treatment very often puts and end to the attack. If it fails, the patient should deeply inhale 6 to 12 drops of pyridine poured on a handkerchief. When the asthmatic attack reaches its climax, an injection of a solution of morphine hydrochlorate is made (1 part in weight to 100 of distilled water). At first 8 minins are injected. If the attack does not abate at the end of 15 minutes, the dose is repeated. Apart from the attacks three medicaments are indicated for combating the diathesis: potassium iodide, arsenic, belladonna. When the asthma is accompanied by emphysema, very favorable results are obtained by compressed air baths.—*Kansas City Med. Journal.*

Puerperal Fever.—In discussing this subject in a recent lecture, Prof. W. Gill Wylie, of the New York

Polyclinic, made use of the following language: "I believe now, and I say it with perfect sincerity, that nine cases out of ten of puerperal fever that I am called upon to treat, in from 12 to 24 hours after the onset of the attack, I will cure by simply regulating the bowels and washing out the uterus systematically and thoroughly at frequent intervals. If you follow the instructions of the text-books you will find that they advise the washing to be done but once in eight hours. I have proved to my own satisfaction the fallacy of this advice. The germs are not destroyed by the first or second washing, and they develop anew in eight hours. If I am called to a case of puerperal fever, and within six hours or so after frequent washing out the temperature does not fall to normal, I make up my mind that the poison has entered the tissues of the patient, and I at once proceed to open the belly. I generally find there an abscess present."—*Ibid.*

Hypnotism.—Dr. Ernest Hart, *British Medical Journal*, concludes an article on this subject with the statement that since no evident advantage has during forty years of extensive, patient, and elaborate trial and research been obtainable by the hundreds of physicians and physiologists who have devoted themselves to the study of the question, it is justifiable to say that the practice of hypnotism, mesmerism, electro biology, and so-called animal magnetism, being almost invariaby useless and often dangerous, even in the hands of the most highly skilled, careful, and conscientious physician, it is a practice which ought to be forbidden to the unqualified, and is a most unfit and improper subject for platform shows. It is equally unfit for private amusement, and dangerous and improper as a society game.

Effects of the Removal of the Suprarenal Capsules.—Professor Dominicis, after a series of experiments, announces the following results:

1. The experiments have confirmed the results obtained by Tizzoni relative to the lesions of the spinal cord (softening, affecting especially the cervical and dorsal portions). He did not, however, like the writer cited, observe the process of ascending degeneration, nor lesions of the cœliac ganglion.

2. He has never seen regeneration or compensatory hypertrophy of the other capsule, or its remaining parts, in animals from which he had removed one capsule and mutilated the other.

3. The fact that when the operation is skillfully performed animals are able to survive the total destruction of both capsules is a sufficient proof that death, in such cases, is not caused by intoxication, as had been thought, but by circulatory disorders consecutive to wound of the vena cava.

4. Pigmentation, described by other investigators (Marino-Zuco, Alezais, and Arnaud), was produced in but a single case.

From the foregoing facts the writer deduces these conclusions:

The fact that profound alterations of the spinal cord are sometimes concomitant with similar changes in the cœliac ganglion, while in other cases that structure is left intact, prove that these lesions do not depend upon each other, but that both must be considered as a consequence of the same cause, capable of acting upon both parts or upon one alone.

The fact that pigmentation has been met with by some observers and not by others proves that its cause should be sought in special circumstances, and independent of the physiology of the capsule.

The phenomenon observed by all experimenters is a trophic trouble manifesting itself at some distance from the time and seat of the operation. This is doubtless an effect dependent upon the trophic and vasomotor system, but regarding which no exact information can now be given.—*La Medecine Moderne.*

Susceptibility of a Patient to a Small Dose of Arsenic.—I was lately consulted by a patient who had been troubled for some time by successive attacks of furunculosis on the neck, and he presented himself to me, a fresh attack being imminent, for the papules had reached the size of a split pea, with surrounding induration and redness. I ordered him three minims of arsenical liquor three times a day, to be taken immediately after food, and well diluted. On visiting him two days later, I found that the furuncles had completely disappeared and aborted, but in their stead he had a universal erythema, least marked on the face and hands; the chest and abdomen had quite a boiled lobster appearance which itched very much and had caused him a restless night; he had also a slight attack of diarrhœa and some suffusion of the conjunctivæ, but no furred tongue or other sign of arsenical poisoning. The temperature was normal. On inquiry I found he had taken only five doses of the mixture prescribed, fifteen minims in all. He told me that ten years previously he had suffered from an attack of eczema, which was caused by working with arsenic, and that he generally suffered yearly in the autumn from a slight attack. The rash disappeared when the arsenic was discontinued.—*Nicholson, in Lancet.*

Hypnotism.—In 1890 the British Medical Association appointed a committee to investigate hypnotism. After an interval of two years the committee, which consisted of some of the most prominent medical men in England, submitted its report. The committee are satisfied as to the genuineness of the hypnotic state, while finding nothing to support the theory of "animal magnetism." The mental and physical phenomena, the report goes on to say, attending hypnotism, vary widely in different cases. Among them may be mentioned altered consciousness, temporary limitation of will power, increased receptivity of suggestion from without, sometimes to the extent of producing passing delusions, illusions and hallucinations, an exalted condition of the attention and post-hypnotic suggestions. On the physical side are seen vascular changes, muscular tremor, inability to control suggested movements, anæsthesia, catalepsy and rigidity. All these phenomena are rarely present in any one case.

The committee raise a warning note against the abuse of the agent, believing that it should be employed only by qualified medical men. They believe it has its place as a therapeutic agent in relieving pain, producing sleep and alleviating functional ailments.

Coming from the reliable source from whence it does, these conclusions will doubtless have much weight with the rank and file of the profession, not only in England, but in this country.

Above the smoke and din of the fierce battle which wages between the Nancy and the Charcot schools, a

few real, solid facts seem to be established, and these have been well set forth by the Committee of the British Medical Association.—*Pitts. Med. Review.*

TREATMENT OF ALBUMINURIA.—Dr. J. M. Da Costa, *Am. Jour. Med. Sciences*, says: We are dealing with a special disease in which mal-assimilation is the main element and the kidney affection only a conspicuous expression, therefore the treatment must not be purely that of Bright's disease which we commonly meet with, but of the underlying state as lithæmia or oxaluria. It is true though, the lines of treatment are in the main similar. It is more essential that the various emunctories should be brought into action than in Bright's disease, as it is this extra work which leads to their damage. *Diet*: (1) Green vegetables and fruit are freely allowed; (2) tea, coffee, and cocoa are permitted if but slightly sweetened; so are limited amounts of oatmeal, buckwheat and corn cakes, rice, bread and butter, also oysters and fish; (3) white meat of poultry and game moderately, but such as mutton and beef which contain nitrogen should be avoided as a rule, except where exercise is indulged in, then such are allowed; (4) milk, only a pint or two daily, as it is not especially useful. Sometimes a vegetable may effect a permanent cure; (5) restrict sugar and beets, as they have a tendency to aggravate the symptoms in lithæmia; (6) prohibit rhubarb plant as oxalates and albumen reappear; (7) salt may be taken freely; (8) flush kidneys well with pure or aërated waters, such as Poland, Highland, Saratoga, Vichy, or Vichey. Hot water at bedtime acts very beneficially in some cases, as it increases flow of urine the following morning, and as uric acid is largely excreted then, it is doubly serviceable; (9) beverages containing alcohol are to be avoided; (10) moderately cold baths followed by systematic skin friction. Exercise in open air diminishes albumen in urine. Among medicines laxatives are very important. A course of ammonium muriate of iron from time to time, tartrate of iron and potassium, or Basham's mixture preferably.

CHEWING GUM IN FEVERS.—The salivary glands play quite an important part in continued fevers, yet they are not considered in the treatment of the case. One of the first and most important restrictions in the patient's dietary is to drop all solid food from the list at the physician's first request, and just then the salivary glands begin to lapse into a torpid condition which very often results in an inflammation, and, finally, suppuration, and that disagreeable dryness to the tongue and fauces so uncomfortable to the patient. For the relief of this trouble I have found nothing of so much importance as some nice form of aromatic chewing-gum, which relieves the thirst and dry mouth, improves the appetite and digestion, and restrains nausea, if any. Hence, some of the most disagreeable accompaniments of the disease are mitigated. I believe, also, that it materially aids the absorption of the medicine when the alimentary tract is so impaired by the incessant fever.

I do not claim originality in this treatment, although I have never found any reference to anything of the kind. However, it may have been regarded as too simple to need mention; still it is, in my estimation, quite important in any continued fever.—*N. Y. Med. Rec.*

ETIOLOGY OF MALARIA.—The latest addition to our knowledge of the bacteriology of malaria has been contributed by Dr. Julius Mannaberg in a paper read before the Society of Physicians at Vienna (*Allgemeine Weiner Medicinische Zeitung*, Zw. 5, 1893). He divides the microörganisms connected with malaria into two groups: (1), Parasites with direct sporulation, without syzygies; and (2), Parasites with direct sporulation and with syzygies. In the first group he places the microörganisms connected with the quartan and tertian varieties of the disease; in the second, the pigmented and unpigmented organisms found in the blood of patients suffering from quotidian ague, and also those described as occurring in the malignant forms of tertian ague. Dr. Mannaberg had observed the latter variety before Marchiafava and Bignami described them, and corroborates these observers in every detail, both as regards the appearance of the parasites and the nature of the disease produced by them. Dr. Mannaberg further demonstrated, by means of special illumination, that the younger forms of all organisms are not found in the corpuscles, as Marchiafava and Celli maintained, but, as Laveran had previously shown, are to be seen adhering to the outside of the red corpuscles. As regards the semilunar bodies in the blood of malarial patients, which have been described by several observers, Dr. Mannaberg states that in forty-three cases of "summer fever" (due to infection by the organisms contained in his second group) he found them thirty-seven times. He considers that these semilunes are formed by the coalition of two to four amœboid bodies and states that he has been frequently able to demonstrate the approach of such bodies to each other and the subsequent appearance of a semilune. Dr. Mannaberg opposed Laveran's views that the semilunar bodies were the result of the cachexia produced by malarial poison, for he had never seen them in the blood of patients suffering from the forms of disease produced by organisms of his first group when the ague had lasted for a very considerable period, but had frequently found them within the first few days of the fever in the blood of patients suffering from the more severe forms (second group) of malarial poisoning, but in which cachexia was not marked. Finally, he considers the treatment of malaria by quinine and maintains that the organisms are destroyed and rendered inert by the action of this drug.—*Lancet.*

A CASE OF ALOPECIA OF THE ENTIRE SCALP.—Dr. E. Mansell Sympson, of Lincoln, England, reports the case of a girl, aged ten, who, three years ago, began to lose the hair. Her eyelashes and eyebrows also fell off; these, however, returned at the end of a year. They are very white in color and very fine. There is no history of ringworm nor of headaches, nor are there any signs of congenital syphilis. She improved some months ago under a lotion of pilocarpine, but relapsed when it was discontinued. At present she is taking one-twentieth grain of nitrate of pilocarpine internally three times a day, and a lotion or ointment of tincture of cantharides, oil of rosemary, and aromatic spirit of ammonia is rubbed vigorously into the scalp night and morning. The outlook is favorable, as the eyelashes and eyebrows have come again.—*Archives of Pædiatrics.*

THE PRODUCTION OF HEAT IN FEVER.—For many years a controversy has been carried on as to the

cause of the rise of temperature in fever, one school arguing that such rise depended on increased oxidation, while the opposite school, of which Traube may be regarded as the exponent, considered the rise to be due to the retention of heat—that is, to a diminished discharge of heat by the body. With a view of settling this question, Professor Rosenthal (*Berlin. klin. Wochenschr.*, August 10, 1891) has recently, with the aid of his air calorimeter, carried out a research on the lower animals, using especially rabbits, in which pyrexia was caused by the injection of phthisical sputum, infusion of hay, etc. The result showed that the discharge of heat from the body was diminished, while the temperature was rising. Traube's view therefore being confirmed. The next point which Rosenthal set himself to investigate was whether during the onset of fever there was any increased production of heat, or whether the rise of temperature might be wholly due to diminished loss. The calorimetric experiments failed to supply any evidence of increased production of heat; in short, the rise of temperature appeared to be wholly due to diminished discharge of heat. Rosenthal is careful to limit the above conclusion to the animals under experiment (that is rabbits), in which pyrexia was produced in the manner indicated. A broader generalization must await further investigation. Nevertheless, a number of observations have already been made on sick persons in state of fever, and the evidence obtained, although not yet complete, points in a similar direction, as stated above.—*Brit. Med. Jour.*

PRECAUTIONS AGAINST CHOLERA.—The *Therapeutische Monatshefte* has published the following rules issued by the Imperial Bureau for the benefit of the German people. The advice is certainly wise and minutely given, and shows the paternal care of the government.

1. Keep your presence of mind in the danger; avoid too great anxiety, for it clouds your clear judgment. Only the man who thinks clearly can make proper use of the precautions against danger.

Maintain cleanliness in your person and surroundings. Discretion, temperance, precise cleanliness, prove the best protection against disease.

Hold firmly to your ordinary regular mode of life. Avoid festivities and assemblages of people.

Avoid medicines as long as you are well.

Visit the sick only when your duty calls you.

Avoid intercourse and close contact with persons who come from cholera regions.

Do not leave your home in order to escape the disease. Consider that you may be in greater danger in traveling, and living under altered conditions in a strange place, than while leading a careful, regular life at home.

2. Do not put other objects besides food and drink in your mouth—*e. g.*—the fingers in turning through a book, pen holders, lead pencils, etc.

Drink as little water as possible, and only such as you know to be above suspicion.

Pure spring water is, as a rule, unsuspicious. Water from deep pipe wells, and from closed pipes, if taken from open waters, such as have been subjected to a genuine filtering, is safe. (Small house filters, unless frequently changed or cleaned, are rather harmful than useful.)

Water from rivers, ditches, ponds, flat, open or poorly-covered springs, also from springs which are near dirt or dung sites, is suspicious during cholera epidemics. All washing and rinsing, as well as pouring out of dirty water near springs, may be dangerous to health.

Suspicious water during the prevalence of, or near, cholera, is only safe to use for drinking, washing the face, rinsing the mouth, washing utensils used for food and drink and the like, after being boiled one minute. The germs of the disease are destroyed by cooking, but fresh germs may again occupy it if it stands long.

To make boiled water taste well, add to each glass (half a pint) as much tartaric acid as you can take on a knife-point, or two drops of hydrochloric acid.

Keep water in clean vessels.

Tea, coffee and cocoa are permitted drinks, also good beer and pure wine.

Beware of ice and very cold drinks.

Let your beer be clear and fresh, neither sour nor insipid; have it served to you in glasses which have been washed with unsuspicious water (when necessary, boiled).

Bitter schnapps often contains aloes, hence, act laxatively and are questionable.

Mineral waters are unquestionable, if they come from natural springs or are prepared with distilled water.

Avoid drinking uncooked milk.

The disease may adhere to butter and fresh cheese, if they were prepared or kept near persons ill with cholera.

Eat fruit and vegetables, also onions and the like, only in a cooked state.

Eat nothing uncooked or unroasted which strange hands have touched, unless you know them to be reliable.

Purchase food only from reliable, clean shops. Avoid such as are in cholera houses.

Avoid all excess in eating and drinking. Be especially cautious if you incline to diarrhœa.

Eat and drink nothing as wholesome which is in a sick room. Consider that flies and such insects might carry the germs of disease from the patient to your food.

Even cigars may convey infection in a patient's house.

3. Keep your head cool, your body warm, your feet dry.

Live and sleep in pure air; fumigations do not prevent contagion.

Wash your hands frequently during the day with water, soap and brush, especially before you touch eatables.

If you have touched any dirty or suspicious objects, first wash your hands carefully with a solution of four teaspoonsfuls of clear, fluid carbolic acid in a quart of water (five per cent carbolic acid solution); then wash this off with clean water and soap.

In cholera regions do not bathe in rivers or ponds.

Use a public privy only in case of necessity. The seats of privies which are used by strangers should be cleaned daily with soapy water. For this take one pound of soap to a pail of hot water. If your privy is used by persons suspected of disease rinse the wall of the funnel with freshly slaked lime (one part quicklime to four parts water.)

4. The infectious material of cholera is contained in the excretions of the patient. It adheres to soiled linen and clothing, and can be transmitted by any-

thing which touches such objects or excretions, even when this occurs indirectly and not in a noticeable manner.

Excretions of persons ill with or suspected of having cholera, and floors, etc., soiled with them, disinfect by copious (at least hourly) use of slaked lime or chlorinated lime solution (five drachms chlorinated lime to one quart of cold water) or other trusted disinfectants.

Linen, clothing, bed clothing covers, and the like, also such as come to you from cholera regions, send well wrapped up and tied, to a public disinfecting institution.

If such is not in reach soak the things twenty-four hours in soap and water (one pound washing soap to a pail of hot water) and then boil thoroughly.

Other soiled objects cleanse thoroughly with such soapy water, with quick lime or carbolic acid solution. If the nature of the objects does not admit of this, then place them for at least six days in an unused, airy, dry place.

Thorough drying is unfavorable to the development of the disease germs.

5. If your digestion is disturbed, if you have diarrhœa, especially with vomiting or great nausea, consult a physician at once.

Until he comes, take a warm drink, put on a woolen bandage about your body, remain in your room; if in great distress, go to bed.

For relief you may take a cup of tea with cognac or rum. Let your food be a mucilaginous soup, also zwieback, or stale white bread without butter.

If you have reliable (prepared from a physician's prescription) cholera drops at hand, take from 20 to 30 drops on sugar.

Keep your presence of mind, even if you are ill. Fright and cowardice act unfavorably on body and mind.—*Woman's Med. Jour.*

Surgery.

THE IDEAL DRESSING FOR THE ABDOMINAL WOUND.—One of my earliest efforts in abdominal surgery was to improve the dressing of the wound in the abdominal wall. The dressings then and now in use consisted of layers of cotton, sterilized or impregnated with antiseptic solutions, or alternating layers of various impermeable and antiseptic substances. The whole purpose of such a method clearly depends upon preventing access of pathogenic germs to the wound by heaping up impassible barriers on the patient's belly. To the practical eye noting the impossibility of affording adequate protection of this sort around the mons veneris and the creases of the thigh, where septic matter is most prone to enter, the inconsistencies are but too evident; for every movement of the patient which slides the dressings a little on the body and tends to displace them, as well as the necessary attentions to the genitals on the part of the nurse, each time open this avenue of infection. Convinced of these facts, I abandoned this form of dressing and adopted a variety of dry and moist dressings, all the time casting about in my mind to determine just what was needed to establish an ideal dressing.

The ideal dressing would seem to be a solution or paste which would quickly harden until it formed a thin, flexible, impenetrable layer over the wound and the surrounding skin, which would be thus hermetically sealed; in this way absolutely preventing any invasion of the wound from the outside, and preserving the aseptic conditions established at the operation. It would also be desirable, if possible, to add to these qualities the property of transparency, allowing the line of the wound and the stitches to remain under constant observation, noting changes without disturbing the dressing. A dressing possessing such qualifications may certainly be named ideal.

My researches have been in large measure rewarded; for, although unable to secure a transparent dressing unaffected by cotton or other protective in contact with it, I have found, and for two years past used, a dressing which hermetically seals the wound in a thin layer, with certainly preventing the invasion of pathogenic organisms from without. This dressing is easily made, simple and always satisfactory. After closure of the incision, the skin, the line of the wound, and the sutures are dried, and two layers of sterilized gauze or cheese-cloth, large enough to project five to ten centimeters (two or four inches) beyond the incision on all sides, laid on the skin. This is saturated with the following adhesive mixture, which is evenly distributed over the whole surface:

℞. Squibb's Ether, or Washed Ether, and Alcohol, absolute . equal parts
Bichloride of Mercury (Merck's recryst) enough to make the solution 1-16000
[Anthony's] snowy cotton enough to make a syrupy consistence added in small pieces, stirring.

As soon as this is poured over the wound evaporation begins to take place at once, and the celluloidin hardens, gumming the gauze fast to the skin. To avoid delay in waiting for this to grow quite hard, and to prevent adhesion to the cotton applied above it, the whole surface is freely dusted over with a finely powdered mixture of iodoform and boric acid.

℞ Pulvis Iodoformi ..... 4 grammes, or 1 drachm.
Acidi Borici. .....28 grammes, or 7 drachms.
M exactissime..... ..... S. Dust freely on wound.

This powder is of itself an invaluable protective. I use it constantly in obstetric cases, separating the labia and throwing it into the vagina, where it acts as a guard to the vaginal outlet against septic invasion from without.

The wound thus sealed with celluloidin gauze may be left untouched for a week or more, when the dressing should be softened with water, or more rapidly with ether, the gauze lifted off, and the stitches taken out.

If there are any signs of suppuration, as evinced by pain, local tenderness, and redness, associated with elevated temperature, the dressing should be removed earlier and the discharge of the stitch-hole abscess promoted in the usual way.

The purpose of cotton heaped up on the abdomen is now no longer protective and antiseptic; it merely serves the purpose of padding out the inequalities for the application of the bandage. Common cotton may be substituted for absorbent and prepared cotton by simply sterilizing it in the Arnold steam sterilizer.—*Howard A. Kelly, M. D., in The Amer. Journ. of Obstetrics.*

THE MANAGEMENT OF SUPPURATION COMPLICATING TUBERCULOUS DISEASE OF THE BONES AND JOINTS.—Dr. V. P. Gibney concludes an article, *Medical and Surgical Reporter*, on this subject with the following summary:

(1.) Protect the joint about which the bone lesion exists in the early stage, and in the later stages, whether the abscess is let alone, aspirated or incised.

(2.) In cases where the suppurative process is confined to a small area, it is good surgery to leave the small abscesses alone if the protective appliance is adequate.

(3.) It is good practice to aspirate where the abscess is in the way of the proper adjustment of apparatus, and by such procedure one may expect good results in at least fifty per cent of the cases aspirated.

(4.) The simple incision of an abscess dependent upon bone disease depends for good result upon the extent of the bone lesion.

(5.) Excision of the hip is not a measure to be employed in all cases where extensive suppuration exists, but must depend largely upon the condition of the patient and the location and extent of abscesses.

(6.) Expectant treatment for the knee and ankle joint in children yields the best results for life and limb.

(7.) Amputation of the ankle in a child is rarely ever justifiable, except when amyloid disease of liver or kidneys threatens, or is present; of a hip after a thorough excision has failed.

(8.) The long continued employment of a good fitting splint to the back in Pott's disease of the spine, will yield better results than any operative procedures on the bone with which I am familiar.

CASTRATION FOR MELANCHOLIA—The operation of castrating males for nervous and mental disorders is at last put upon a firm clinical basis. Oophorectomy came from the south, and thence diffused its genial and unsexualizing influence over the east and north; but testectomy, if we may coin a word on so great an occasion, comes from the west. It was in 1891 that the Eastern Michigan asylum published an annual report containing the history of a case in which the operation of castration was done for the relief of a "sickening neuralgia" of the testicles. The patient had not only neuralgia, but melancholia. One of the testicles was removed, and the testicle was found diseased, but not as we understand the description, cystic or suppurating. The patient improved, but was not cured; and so, later, the second testicle was removed. The medical superintendent, Dr. Burr, now reports that the cure is complete. It is interesting to notice that both testicles had to be removed, just as in the opposite sex, we are told that both ovaries ought to go in order to get the best results.

Here we have a case of chronic neuralgia and melancholia, in a man of fifty-seven, cured by castration. Neuralgia is very common, and so is depression of spirits. There is a fruitful field, therefore, in which ambitious andrologists may work. Shall we not soon begin to get reports of "my second series of one thousand castrations, with hints on technique?" —*N. Y. Medical Record.*

Dr. R. E. McVey, of Topeka, reports two cases of melancholia cured by castration. The first operation was done in 1888, for chronic ataxy and melancholia, resulting from masturbation. Both testicles were removed, and the cure was complete. The second operation was done in 1891 for melancholia and neuralgia of the testicle. In this case only one testicle was removed, and it was found to contain a large cyst and evidences of previous inflammation. A perfec cure resulted.—*Miss. Medical Monthly.*

REPORT OF A CASE OF APPENDICITIS.—In the *Annals of Gyn. and Paed.* Dr. M. Price reports the following interesting case:

In this case Mrs. R. S. suffered for a number of years with what was supposed to be liver trouble. There was tenderness all over the right side of the body. She was treated by a very intelligent physician. She suffered from numerous attacks of malarial fever. No examination was made, as there was no suspicion of any other trouble up to within eighteen months of her death, when her physician discovered a large, symmetrical tumor filling up the entire lower abdomen. A number of good men had examined the case, and a number of different opinions given as to the character of the trouble, none of which were correct. Operation was refused for the reason that in her greatly emaciated condition, and owing to the feeble character of her heart, no encouraging prognosis could be given. This large tumor ruptured and discharged through the bowel. The patient greatly improved and went about. She had a number of mild attacks extending over the last eighteen months, and then the tumor again enlarged and ruptured, but she was not able to rally from the septic condition brought about by the suppuration.

Post-mortem of Mrs. R. S., made by Dr. A. G. B. Hinkle: Body moderately well nourished; liver fatty; a large abscess at the end of the appendix; the appendix open, communicating with the bowel; abscess adherent to all the pelvic organs, and extending from crest of ilium to crest of ilium, and a well-marked tumor in the middle of the abdomen. The abscess extended back of the uterus over to the left side of the body: womb and appendages normal save adhesions to the abscess; abscess full of pus and contents of bowel.

An operation would undoubtedly have saved her life. In the multitude of opinions there was nothing done.

ORIFICIAL SURGERY.—Dr. Joseph M. Matthews, *Indiana Med. Journal*, makes the following pertinent comments on this new fad: "I desire to call attention to a ridiculous and dangerous practice that is being perpetrated upon an "innocent" public by the followers of the homeopathic school, viz., the excision of a portion of the lower rectum for supposed disease. A few years ago what purported to be a great anatomical discovery, was heralded abroad by one of this faith, said discovery being that all mankind (women and children included) were liable at any time to be attacked by "pockets and papillæ" in the rectum; and that the "lesions" in consequence were very dreadful. It was said that this condition was "the most mischievous of all rectal affections," and it was advised that these dreadful "pockets" be "excised" at once. Instruments were invented for the purpose and sold "at a small cost," so that they were in easy reach of all. The consequence was that the itinerants were quickly supplied and the work went bravely on. Such a commotion was created, so many blunders made, and so much suffering resulted, that the regular profession was forced to give this new theory some attention. We are much indebted to Dr. Edmund Andrews, of Chicago, for an exposure of their nefarious schemes. Upon investigation Dr. Andrews found that the parts being excised under the

nom de plume of "pockets" and "papillæ," were the normal structures of the rectum—the sacculia Horneri. In regard to them, and criticizing their removal, he says:—"The sacculi Horneri are not lesions, and usually do not harm; on the contrary they, in conjunction with adjacent grooves and concavities, hold the reserve of mucus required to lubricate the anus."

In evidence of the correctness of his position he publishes a letter from Prof. Henry N. Smith, a distinguished anatomist. Dr. Smith says:—"The rectal pouches (sacculi Horneri) are normal structures intended to hold mucus, which is forced out in defecation to lubricate the margin of the anus and protect it from hardened feces."

Ever since the promulgation of this false anatomical doctrine, I have taught that these structures are normal and should not be interfered with, and in corroboration of this opinion I embraced in my book on Diseases of the Rectum, the views as expressed by Professors Kelly, Bodine and Dugan, eminent anatomists and teachers in the different medical colleges here.

Now, it must be understood that patients suffering from such diseases as asthma, dyspepsia, headache, etc., are told that their disease is due to these "pockets," and an operation for their removal advised. A prominent merchant of this city consulted me lately, who had been told by an "orificial" surgeon that his violent and painful dyspepsia was due to a fearful ulceration, and other diseases in his rectum, and that an operation was imperative. Upon examination no ulceration was found, and nothing simulating disease, except an atrophied pile. Of course his rectum had nothing to do with his dyspepsia. It can be easily seen that by excising these normal structures of the rectum an abnormal or diseased condition might result. For instance, the sacculi Horneri supply the mucus necessary to lubricate the parts with mucus during the act of defecation. When they are destroyed or removed, of course their office is dispensed with. But beside this the operation begets disease as inflammation, ulcerations and strictures of the gut. Each and all of these have fallen under my observation in patients who submitted to the treatment.

New Treatment of Cancer.—The *International Journal of Surgery* contains the following resumé of Adamkiewicz's experiments and conclusions. He regards the cancer cells as independent living organisms and as the parasites of cancer, terming them sarcolytes, a special form of cocci. According to this theory cancroin is the metabolic product of these organisms, and hence in accordance with the teachings of Pasteur, Koch, and others, should exert a destructive effect upon the microbe, on the same principle as Pasteur's protective inoculations in rabies. In the further course of his experiments Adamkiewicz found that certain alkaloids extracted from the tissues of cadavers shortly after death exhibited poisonous properties, resembling in kind and degree those of cancroin. Among these cadaveric poisons neurine was found to be practically identical, both as regards chemical composition and physiological action, with cancroin. Therefore, to determine clinically whether neurine might not prove a substitute for cancroin, he employed it in a case of cancer of the lower lip by the method of subcutaneous injection and found that it exerted specific curative effects, both upon the growth and its metastases. The neurine is employed for the injections in a twenty-five per cent aqueous solution neutralized with citric acid, with addition of carbolic acid, and diluted with double its volume of water. The remedy was found to exert both symptomatic and specific effects; the former being sedative, analgesic and disinfectant, the latter consisting in a destruction of the cancerous tissue by a process of absorption, inflammation, and necrosis.

The successful results thus far achieved by this method would seem to argue in favor of its utility, and, at any rate, render it worthy of further experimentation. It has been objected to by Prof. Kaposi and others who have had an opportunity to observe the patients treated by Adamkiewicz, that the action of cancroin is simply that of a local irritant, similar to that of the caustics employed in the treatment of epithelioma; but in view of the fact that in most of cases the injections were made at a distance from the growth, this theory will not serve to explain whatever virtues are possessed by the new cure of cancer. In the twenty-five cases of carcinoma in which injections of neurine (or as the author also terms it cancroin) were resorted to, the results certainly appear excellent when viewed from a clinical standpoint. Whether a permanent cure, however, can be effected time alone will show.

The Closure of Defects in Bones.—In a communication emanating from Prof. Trendelenberg's clinic, the author describes a new procedure for hastening repair in cases of defects in bones. It consists in filling the osseous cavities with some firm material which will act as a substitute for the destroyed tissue. For this purpose plaster of Paris was tried in the case of a child four years old, who presented a defect of the tibia, of the size of a hazel nut, which had resulted from removal of a carious focus. The cavity was disinfected with sublimate solution, wiped out with iodoform gauze, and filled with a mixture of plaster of Paris and five per cent carbolic acid solution. The cutaneous wound was then closed, and a cure effected in three weeks.

The author regards this procedure as useful in bone tuberculosis and for the treatment of bone defects remaining after extraction of sequestra in cases of abscesses of bone, osteomyelitis and osseous tumors. To disinfect the cavity it is filled with olive oil which is heated to the boiling point by insertion of the Paquelin cautery. In this way all recesses of the cavity are disinfected.

The advantages of the method are that the period of healing in these cases is considerably abridged; that excellent scars result, and that protracted suppuration is avoided. The only difficulty experienced in this procedure is to thoroughly remove all diseased tissue and carefully disinfect the wound. In cases where extensive suppuration with formation of fistulæ exists, the method should not be resorted to until the disease of the soft parts has been cured. It is likewise contraindicated where an existing bone tuberculosis is directly connected with tuberculous affection of the joints, or where the osseous defect is very extensive and the healthy bone substance seems too weak to give the bone the necessary degree of firmness.—*Beitrage fur Klinische Chirurgie, Int. Jour. of Surgery.*

Treatment of Sprains by Massage.—To this well-known mode of treatment, Dr. Rosenblith has added

some new variations which he describes as very successful, in a communication to the *Societe Medicale du XIIe Arrondissement de Paris*. He does not make use of the elastic band, although he by no means underrates its usefulness.

What he particularly wants to show is that effusions of blood are very rapidly reabsorbed by massage. The injured articulation is at first immersed in very warm water, in order to dilate the superficial vessels. After this preparation of the affected region, massage should be practiced *outside* of the injured part. It is then gradually approached, and a very gentle stroking is applied to it at first. After that, more vigorous frictions are practiced.

Insensibility is thus gradually produced. When partially obtained, a more or less energetic *kneading* is practiced, according to the varying degree of sensibility experienced by the patient. To the massaged part is finally applied a compressive bandage, with wadding, which is wrapped in a flannel or linen band.

If the sprain occurs in the inferior limbs, the author, contrary to the ordinarily commended practice of avoiding movements for a shorter or longer period, advises the patient to walk as soon as he can do so without feeling great pain. According to the author, walking adapts the articular surface in a natural way, and actuates the venal and the lymphatic circulations by the muscular contraction.—*Merck's Bulletin.*

EXOPHTHALMIC GOITRE.—P. J. Möbius, (*St. Petersburg Med. Wochenschrift*) has collected the main symptoms occurring in this disease from the widely distributed literature on the subject:

1. Examinations of the eyes show exophthalmus, unusual space between the lids (Stellwag's sign), retardation in the movement of the upper lid (Graefe's sign) insufficiency of convergence, frequent paralysis of the ocular muscles of an intracerebral character, tremor of the eyelids and nystagmus.

2. Examination of the heart shows increase in frequency, systolic murmurs at base of heart, cardiac weakness and angina pectoris.

3. Enlargement of the thyroid gland may precede the other symptoms by years.

4. The skin shows diminished resistance to the electrical current (Vigoureaux), vitiligo, pigment spots, urticaria, a bronze coloration of the skin, redness, increased perspiration, loss of hair, and œdema of the lower half of the body.

5. Increase in the number of respirations, and cough; diminished distension of the chest after respiration, painless diarrhœa without a demonstrable cause, vomiting, boulimia, icterus, atony of the intestines and amenorrhœa.

6. Fever is observed in all stages of the disease; it may be ephemeral, remittent or intermittent; anæmia, and emaciation may be present.

7. The nervous symptoms are tremor, paraplegia, cramps, muscular atrophy, and disturbances of the mind.

8. The disease may be complicated with epilepsy, hysteria, paralysis agitans, glycosuria, polyuria, tabes, myxœdema, or syringomyelia.

9. Regarding the frequency of the individual symptoms, palpitation of the heart and swelling of the thyroid gland are never absent; pallor, emaciation, tremor, Stellwag's sign, and increased moisture of the skin are almost never absent; Graefe's sign, insomnia, and sensation of heat are frequent; pigmentation of the skin, diarrhœa, vomiting, insufficiency of convergence, and increase in the number of respirations, are often present. The disease is more frequently observed in females in the middle period of life. Etiologically, a neuropathic disposition is of the greatest importance; then follows rheumatism, influenza, climatic changes and traumatism. The course of the disease varies; remissions are frequent and cures questionable.

10. Pathological anatomy has disproven disease of the sympathetic as a cause of the affection. Superficial hæmorrhages in the floor of the fourth ventricle have been observed in a few instances; there has also been observed enlargement of the thymus and lymph glands.

11. Therapeutically, besides such remedies as iron, arsenic, belladonna, bromide, etc., electricity, applications of water, and extirpation of the thyroid gland may be mentioned. Regarding the latter, Lemke says, "that patients with exophthalmic goitre belong not to the physician but to the surgeon." Möbius attributes the disease to a primary affection of the thyroid gland of toxine origin.—*Med. and Surg. Journal.*

LEWIN ON CIRCUMCISION—Lewin strongly objects to circumcision as a sanitary measure. By removing the prepuce the glands of Tyson are lost, the fat is lost and there is a resistant cicatrix left. The Bible does not refer to the operation as conducive to health, but was at first only a compromise with Moloch for the sacrifice of the first born. As a religious rite it is a relic of heathenism; as a hygienic measure it is injurious; while as a prophylactic, it is a measure designed to encourage illegal sexual intercourse.

THE EDISON CURRENT FOR CAUTERY PURPOSES.—In the *New York Medical Journal* for February 4th, Dr. Edward J. Bermingham, Surgeon to the New York Throat and Nose Infirmary, describes a very ingenious apparatus which he has devised for controlling the Edison current so that it can be used direct for galvano-cautery operations. The apparatus consists of a *rheostat*, made of coils of iron wire and a handle. The peculiarity of the handle consists of its having solid conductors, and the circuit is therefore always closed. It is under the control of the operator's thumb at all times during the operation, and the current can be cut off from, or allowed to pass to, the knife instantaneously, and without producing an arc. The apparatus is simple and inexpensive, and, from the detailed description given, any electrician can construct it. Dr. Bermingham has been using it for two years and a half for all his cautery operations.

PEROXIDE OF HYDROGEN IN GONORRHŒA.—A couple of months ago peroxide of hydrogen had quite a boom in the treatment of gonorrhœa. Several reports were made by various physicians of its almost miraculous effects, particularly in virgin cases. It was used as an injection three times a day, undiluted ten volumes strength. It was claimed that the powerful antiseptic properties of the drug rendered it superior to the older remedies, and that it possessed the virtue of being unirritating. The drug has received an extended trial in the outdoor department of Bellevue Hospital and has been found wanting. It has no advantage over the older remedies, and in most of

the cases seemed to have no beneficial effect in cutting short the progress of the disease. Certainly it does not abort it, as has been claimed, no matter how early in the disease it may be used. It seems that it requires a long time for some of the profession to become aware that gonorrhœa is not built on the abort plan.—*Med. and Surg. Reporter.*

NEW METHOD OF TREATING FRACTURED THIGH.—At the Medical Society of London, Mr. C. B. Keetley explained a new operation for maintaining the fragments in position after fracture of the femur. The operation consists in passing long steel needles through the fleshy parts into the respective fragments of bone. Mr. Keetley exhibited a case treated by the above method, and pointed out that little or no irritation was caused by the presence of the needles, and he claimed to have provided a means of combating the tendency to shortening in a class of cases in which it was otherwise almost unavoidable. Mr. Jonathan Hutchinson demurred to the proposal on the ground that the long splint, if properly applied, secured good union with a minimum of shortening. The operation is one that might be necessary in certain cases, when the fragments cannot be kept in position, but in the large majority of cases good results may be insured by using the long splint.—*Hosp. Gaz.*

Therapeutics.

HYDROTHERAPY IN HYSTERIA.—In a series of articles published in the *Gazette des Hopitaux*, the author, after according the first rank to the psychic treatment of hysteria, attempts to establish the essential indications for the *external* treatment, to which he assigns the second place. The scope of this treatment comprises, according to the author, hydrotherapy, electrotherapy, and kinesitherapy.

Hydrotherapy is *preeminently* the best method for the external treatment. It is indeed that to which recourse ought to be had in a vast majority of cases, if not in all. Most frequently preference should be given to cold douches (13°–18° C, [55°–65° F.]) on the trunk, then on the feet (the whole for fifteen to twenty minutes), followed by frictions. Douches are applied once or twice a day. In cases where it is impossible to apply such treatment, recourse should be had to wrapping into wet sheets or to ablutions with a sponge. Contrary to what often is said, sea baths are useful, but only in the temperate zone, and for three minutes *at most.*

All the applications of *kinesitherapy* are beneficial (gymnastics, massage, general muscular exercise.) Massage is really effective. According to the manifestations of the neurosis, various modifications of the kinesitherapeutic treatment are to be applied (centripetal stroking, kneading, tapping, friction.) In convulsive forms general kneading is useful. In cases of persistent contractions and rigidity centripetal stroking is attended with good results.

The diverse modes of external treatment may be employed together, particularly hydrotherapy and massage, which can be employed also during isolation.—*Dr P. Blocq, Jour. of Balneology.*

ACETANILID IN THE TREATMENT OF EPILEPSY.—Dr. Theodore Diller, *Pitt's. Med. Review* states his conclusions on the subject as follows:

1. That in all cases in which the drug was given continuously there was noted a reduction in the number of fits, ranging from about 25 to 75 per cent, as compared with other months during which patients were on bromide and tonic treatment alternately.

2. The remedy was in all cases well borne, producing no apparent mental or physical depression. This in marked contrast with the depressant effects noted after a course of bromide treatment.

3. No skin eruption was produced.

4. In any given case, in which a great number of fits are occurring, and where it is desirable to control them as soon as possible, the bromides would be of far more value than acetanilid.

In commenting on the table appended to my paper, the *London Lancet* points out that the effects of acetanilid were most marked after the drug had been employed three months. This is true. But after the fourth month the effects of the drug became less and less noticeable.

In my service at the Pittsburgh Free Dispensary, acetanilid has been given to all epileptics, and in no case has it failed to have some controlling influence over the fits, if statements of patients may be relied upon. One woman, who formerly seldom went longer than a month without a fit, has had none since July. In a case in my private practice, in which the spells are always nocturnal, I have given acetanilid three times a day and a large dose of bromide at night, with the result of markedly lessening the number of the fits.

I generally give the drug in five-grain doses. The drug certainly deserves a more extensive trial at the hands of the profession than it has yet had. After the bromides, it is by far the most valuable drug that I know of, and in certain cases it is of even more value than the bromides.

TREATMENT OF NIGHT SWEATS OF PHTHISIS.—Dr. d' Amore has published his experience with picrotoxine and atropine in the night sweats of phthisis. (*Nouv. Remédes* in *Med. Record,* Dec. 24, 1892). He gives the picrotoxine in granules containing $\frac{1}{100}$ of a grain each. The author reports forty-five cases thus treated. In fifteen advanced cases he gave without success two pills of atropine containing $\frac{1}{65}$ of a grain each daily; in these cases two to four granules of picrotoxine, continued for several days, relieved the condition very much. In twenty cases, with less pronounced lesions, atropine did well in some and failed in others; but picrotoxine used for several days, checked the sweating completely. Finally, in ten early cases, the results were equally good from the use of either drug. The writer explains these differences by the cause of the sweating in the several stages of the disorder. In the early stages much of the sweating is due to the action of the secretory nerves, and these are controlled by atropine; later the sweating is due more to paralysis of the vasomotors, and as atropine does not act upon these it loses its power, while picrotoxine, which does act upon the vasomotor system, retains its value in the advanced stage.—*Col. and Clin. Record.*

ANTISYPHILITIC TREATMENT; PROPER DURATION.—This is one of the most interesting and, as is well known, most disputed questions of medical practice. The physician is often puzzled in making a proper choice, and in the end, and after much hesitation, generally decides upon what in his experience has been the mean duration of treatment. But how often

do we see patients who, after having been under medical supervision for a length of time, abandon the doctor to treat themselves—believing to have a sufficient experience to permit them to do so, and thus destroy their constitution by a too prolonged use of mercurials when the latter are no longer indispensable, yea, often even harmful!

In a communication to the Paris Société de Thérapeutique, Dr. Bontemps, of Saumuz, supported the doctrine of Prof. Fournier, who asserts that in no case can the duration of the antisyphilitic treatment be fixed at less than three or four years. As, at the same time, the patients ought to observe in the medication certain alterations and periods of repose or dishabituation, Dr. B. has arranged the following table, a convenint vade-mecum for the practitioner:

First year:
- 6 months of mercurial treatment.
- 3 months of potassium iodide.
- 3 months of repose.

Second year:
- 2 months of mercury.
- 5 months of iodide.
- 5 months of repose.

Third year:
- 2 months of mercury.
- 5 months of iodide.
- 5 months of repose, and sulphur baths.

Fourth year:
- No mercury.
- Potassium iodide, with intervals of repose and sulphur baths.

—*Merck's Bulletin.*

Iodide of Strontium.—*The Epitome of Medicine* reproduces the Laborde and Malbec's study of this drug which appeared in *La Tribune Médicale:*

They find that it is analagous to that of potassic iodide, but less enegetic than the latter. Their experiments have been principally in the line of finding out the effects of the new remedy on the heart and circulation. After an intravenous injection of a ten per cent solution of the remedy, there has been noticed upon the manometer curve a rise in arterial pressure. It comes on quickly, and is attended with an increased heart. rate. The latter effect, however, is only temporary, and is succeeded by a slowing of the original cardiac action. The pressure alteration is of longer duration, but the remedy is to be regarded as one of comparatively short effect. The authors admit the fact that the injection of distilled water into the veins will reproduce the arterial rise, but the other effects noted above do not follow. The strontium salt is innocuous and can therefore be used under the same general therapy as the iodide of soda and potash, without many of the disadvantages and dangers which these salts and particularly the latter possess. It does not upset the stomach. There are no headache, coryza, salivation, or cutaneous eruptions. No claim is made that the strontium salt is of any service in the syphilitic condition.

The remedy can be given in 30 grain doses, either in distilled water or syrup. It is better to commence with 15 grain doses and gradually increase.

Strychnine in the Vomiting of Debility.—Dr. Smith cites a case where a British officer suffered intensely from obstinate vomiting and great debility as a sequence of malarial fever. He tried all known agents reputed as useful in such conditions, but they only had a passing effect. As a last resort, he tried strychnine in large doses, and was surprised to find that within twenty-four hours it had controlled the condition and continued to control it effectually so that after a few weeks the patient, who was almost like a living skeleton, became fit to go about and do light duty. The movements of the stomach in the above case seem to have been due to the derangement of the centers which preside over it, whereby the stimulus of food, which in health excites the physiological rhythmic contractions of that organ, in the diseased and inevitable condition in question was sufficient to excite the act of vomiting.—*British Med. Journ., Epitome of Medicine.*

Permanganate of Potassium, the Best Antidote for Phosphorus.—E. Q. Thornton, M. D., Demonstrator of Therapeutics of Jefferson Medical College, after a series of experiments, detailed in full in the January number of the *Therapeutic Gazette*, comes to the conclusion that permanganate of potassium is the best antidote for phosphorus. It must be given before the poison has been absorbed, must be well diluted (one part to two hundred of water) and must be given in considerable excess. The reaction forms black oxide of manganese and a solution of phosphoric acid and phosphates.

Tannin and Boric Acid in Dysentery.—Dr. E. A. Lieberson reports two cases of acute dysentery, in girls aged 8 and 12 years respectively, which he had successfully treated by means of warm (36° C [97. 8F]. enemata of tannin and boric acid. The clysters were administered every three hours, and consisted (according to *Vratch*) of 150 grammes [5 fl.oz.] of a 4 per cent solution of boric acid, 0.6 gramme [10 grains] of tannin, 0.25 gramme [4 min.] of opium tincture (Ph. Ross), and 1 to 1½ tumblerfuls of warm boiled water: they were retained for one or two minutes.

As the result of this treatment the intestinal hæmorrhage was promptly arrested, the stools were speedily restored to their normal character, the tenesmus and pain were rapidly relieved, and the course of the disease was materially shortened—convalescence being established in a few days.—*Merck's Bulletin.*

Silver Nitrate Anew Lauded in Recurrent Epistaxis.—It is known that nasal hæmorrhages may be due to certain general affections, but that as a rule they have a purely local origin and arise from an erosion of that part of the anterior surface of the septum where there is a small artery running vertically and lying on the cartilage of the septum and covered with a very delicate mucous membrane. In individuals subject to recurrent epistaxis, there is found in that region, upon examining it with the nasal speculum, a small blackish crust. If this scab be lifted with the sound, blood will immediately spurt from the denuded point.

To definitively cure the patient of his recurrent epistaxis, all that is necessary is to obtain the cicatrization of that erosion, and for that purpose recourse must be had to cauterizations. The galvano-cautery and chromic acid, which are generally employed with that object by laryngologists, have their drawbacks. In fact, the galvano-cautery is usually not in the possession of the regular practitioner; and as for chromic

acid, its caustic action is hard to limit on account of its deliquescence, and, furthermore, it is a toxic substance whose employment demands some circumspection.

Dr. P. Houdeville, of Rouen (France), in his inaugural thesis on the subject of epistaxis, gives the preference to silver nitrate in the treatment of the nasal erosions in everyday practice. He uses it in the following manner (*Sem. Med.*):—

If the cauterization is to be practiced at the very moment of the hæmorrhage, which is frequently the case, the inferior part of the nasal septum is compressed either by an assistant or by the patient himself (simply pressing the alæ quite forcibly against the septum with the fingers). A few probes are armed with small cotton tampons impregnated with a twenty per cent solution of cocaine; and on a flat probe, a crystal of silver nitrate is melted. Then, after having the patient blow his nose, the speculum is rapidly introduced, the region of the septum from which the blood proceeds is wiped dry, and the tampon saturated with the cocaine solution applied; a few moments are then allowed to elapse. Under the influence of the vascular contraction determined by the cocaine, the hæmorrhage diminishes, and it becomes an easy matter, after having withdrawn the tampon, to find the bleeding point, to which is then applied the crystal of silver nitrate. This is left in place a few instants and withdrawn when a sufficient scar has been produced. The patient can then blow his nose, even violently it is maintained, without any hæmorrhage being provoked.

Two séances are all that is needed, it is claimed, to produce a scab, after the detachment of which the erosion will be completely cicatrized.—*Merck's Bulletin.*

Treatment of lead colic by large doses of olive oil.—Dr. Weil, of Lyons, France (*La Semaine medicale*) has treated five cases of lead colic successfully with large doses of olive oil. He administers a glass of the oil per diem, and in all the cases a cure was effected in three to five days, concluding with the appearance of copious stools, produced by the oil. But, before the stools, considerable diminution of the pains takes place, thus proving that, besides its action as a purgative, it exercises a certain analgesic effect upon the intestine. In one of the patients two glasses were rejected by the stomach, while the third produced an amelioration and a cure. Another patient, in whom belladonna and purgatives brought about no results, was relieved by the first glass of the oil and cured by the fifth. In all the cases of plumbism the oil not only caused a disappearance of the colic, but also of the other symptoms—myalgias, arthralgias, cutaneous anæsthesia, headache and vertigo.—*Med. and Surg. Reporter.*

Iodoform versus aristol.—Under this head Dr. Richard H. Gibbons, of Scranton, gives a very interesting account of his experience with aristol. The first case in which he employed it was after an operation for the removal of a cancerous mammary gland. The entire wound approximation was dusted with aristol. The lesion was dressed and closed for eight days, when it was found that a complete union had taken place. "Since then," says the author, "I have used aristol for all wound surfaces, exterior and cavital. In all operations about the anus and rectum I have found this remedy of great value.

Dr. Gibbons had equal success with aristol in diseased conditions of the eye, ear, nose, vagina, cervix, the female urethra, etc. He made satisfactory use of it also in supra-pubic cystotomy and internal urethotomy. The author adds that: "The powerful effects of aristol to promote rapid cicatrization" led him to employ it for special operations for the relief or cure of malignant disease of the female mammary gland. In the six cases cited the success achieved was remarkable. Concerning the value of aristol as a protective, Dr. Gibbons writes as follows: "The results which I have obtained in the use of aristol as a protection to wounds and ulcerated surfaces, and also as a stimulation to granulation, have been satisfactory to an extreme degree." Of its value in cœliotomy he says: "In all cases of abdominal surgery I now use aristol, and find it to be the ideal protective, having had no cases of breaking down of the wound of entrance, as has happened in several cases where I have used iodoform.—*Med. Bulletin.*

Diuretin.—Dr. James B. Herrick has made a thorough study of the literature of this drug and used it extensively in his own practice. His results as summarized in an article of the *Journal Am. Med. Assn.* are subjoined.

1. Diuretin is a diuretic acting by direct stimulation of the renal epithelium and best suited to cases in which there is general dropsical effusion.

2. It is the best medicinal remedy for removing dropsical fluid due to valvular disease of the heart, after digitalis and pure cardiac tonics have failed.

3. It can be advantageously combined with digitalis and pure cardiac tonics.

4. It probably has a direct effect upon the heart as well as upon the kidney, slowing and strengthening its action and improving its rhythm. (This is disputed by some, viz.: Cohnstein, *Ueber den Einfluss der Theombromine, etc., auf den arterillen Blutdruck.* Inaug-Diss., Berlin, 1892).

5. Diuretin has oftentimes a beneficial effect in other circulatory diseases with dropsy, as myocarditis, pericarditis, aneurism, arterio-sclerosis. Its action is here more uncertain than in valvular disease.

6. In the dropsy of nephritis it can be used without danger of irritating the kidney, the effects in acute nephritis being more certain than in chronic nephritis. Where the renal epithelium has undergone too extensive degeneration, the drug may fail to act.

7. In the dropsy of portal obstruction, and especially of cirrhosis of the liver, it usually fails to give good results.

8. It occasionally causes nausea, vomiting, diarrhœa, palpitation, headache and slight fever; rarely, skin eruptions follow its use.

9. The maximum daily amount that can be given with safety is 150 grains; the average daily amount is 50 to 120 grains, given in divided doses. When combined, in heart cases, with cardiac tonics, smaller doses of diuretin can be employed.

10. It should be given in solution in water or milk, or in pill or capsule, without acid and by preference between meals.

The Action of Chloroform Upon the Human Being.—Careful anatomical and pathological studies on this subject by Dr. E. Fraenkel, of Hamburg, led to the following contribution: He recognizes in long continued chloroform narcosis a dangerous poison

upon the human tissues. He has been able to observe four cases, three male and one female. Two of these having died forty hours after having been respectively three to four hours under the influence of chloroform.

The third died eighteen days after having been under chloroform three hours, while the fourth died five days after the operation—the operation having consumed two and a half hours.

The author's studies in connection with the pathological changes correspond in the main with those examinations made by others on patients who have died from prolonged chloroform narcosis, in that the kidneys and liver have suffered from necrotic changes of a specific character in their parenchymal cells. Comparatively speaking, the heart seemed to suffer the least, even though this organ has never been found thoroughly intact. Up to the present date there is still a lack of pregnant symptoms which will permit of a decided opinion from a clinical standpoint on the subsequent action of chloroform; although there is after a prolonged period of chloroform narcosis an excretion of a sulphurous substance similar to cystin in the urine. Chemical and anatomical investigations have decided that the protracted use of chloroform will induce rapid retrograde changes in the organism.

The substances which are most frequently attacked are not yet clearly demonstrated; it is still an open question if its deleterious effects first attack the tissue cells of the organs in question, or if aside from this the changes in the blood lead to a destruction of the red blood corpuscles.

In closing, the author states that his studies on both animal and man regarding this subject, have led him to think that there is a difference in the individual susceptibility which would explain the apparent freedom from its deleterious effects in some weak individuals.—*Virchow's Arch., Med. and Surg. Reporter.*

Obstetrics.

Post-partum Hæmorrhage.—After assurance that the uterus is empty, and ergot with local applications has failed, Prof. Grynfeel (*Medical and Surgical Journal*, Atlanta), advises the use of large quantities of hot water thrown directly into the uterine cavity, protecting the perineum from injury by application of vaseline. Should this not succeed, then pressure of the abdominal aorta is the next resort. This should be done by placing the left hand directly back of the fundus, with the other hand in front close to the first. Pressure must be exerted and maintained continuously for a time. Bawdelocque kept up the pressure for four hours. Another important method is the intrauterine tampon. The uterus is brought down into view. Then long strips of iodoform gauze are carried up to the fundus by means of a probe, and packed snugly in position. It is necessary to have a free end projecting from the os to facilitate removal, which should be done after twenty-four hours, and uterus repacked should bleeding become evident.—*Annals of Gyn. and Ped.*

The Induction of Premature Labor by Injection of Glycerine.—In an editorial the *Annals of Gyn. and Paed.* describes as follows this recently devised method of inducing labor at the time of election.

The mode of introduction of the glycerine is simple, a glass syringe, a piece of rubber tube and a No. 9 (English) olive-pointed, braided silk catheter being used. Pelzer appears to have confidence in the antiseptic properties of pure glycerine, while Edgar boils his glycerine. It must be remembered that like all other obstetric manipulations this procedure must be performed with the strictest antiseptic and aseptic precautions, for a failure in the least particular might infect the woman. It is also especially necessary to see that not a bubble of air remains in the catheter, tube or syringe. From one-half an ounce (Edgar) to four ounces (Pelzer) of glycerine may be used, the cervix being drawn down with volsella forceps after a sufficient preliminary scrubbing and douching of the vagina and external parts, and then the catheter is inserted six or eight inches within the os, passing between the membranes and the posterior wall of the uterus. The patient remains for some time with the hips well elevated.

Pelzer attempts to explain the action of the glycerine by its abstraction of water through the membranes, but it appears that there is some specifically stimulating action on the uterus. What this is we fear can never be explained—perhaps the best way is to imitate the celebrated doctor in the play who, when confronted with the question why opium produces sleep, boldly replied that it was on account of its inherent dormitive properties.

At any rate the fact is established that glycerine thus used will powerfully stimulate uterine contractions, and the further development of the procedure will be awaited with the greatest interest.

Double Placenta.—Dr. J. B. Hester, of Euclid, Howard Co., Ark., reports (*Weekly Med. Rev.*) the case of a thirty-year-old vipara whom he delivered of a seventh child, a fine boy, weighing nine and a quarter pounds. Around the child there was a veil, a thick substance like a bladder or winding sheet, that completely covered the child from head to foot. He unwrapped the child and found the veil some two feet long by eighteen inches wide, in oval shape, and only grown at the naval to the child and the cord. Some three inches from the child it was forked, and there were from the child two separate cords to two separate placentas. The mother had an easy time, and was soon up, and did well, as also the child. Cases ofthis kind are far from exceptional.—*Medical Standard.*

Pubic Symphyseotomy.—The first Canadian case of this operation, which is the fourth American, is reported in the *Montreal Medical Journal* for January as having been performed in that city on December 5th. The surgeon was Dr. J. A. Sprengle. The subject of the operation was a primipara of Irish parentage. Both mother and child have done well. The indications for the operation were found in a pelvic contraction, as regarded the mother, and in the large head of the infant. Dilatation of the cervix uteri was complete on the 4th, the day before delivery, with no descent of the head. The forceps, under anæsthetics, failed to bring relief. The "crying of the child *in utero*" is said to have been "distinctly heard by those present." The surgeon, having the assistance of Dr. Lockhart and Dr. Kenneth Cameron, decided to sever the symphysis. Special care was taken to keep the urethra away from the path of the incision, and no complications were encountered. When the symphysis was cut through the two sides sprang

apart, leaving an interval of about an inch. Lateral support was given to the pelvis, the forceps was again applied, and delivery was rapidly accomplished by Dr. Lockhart. The infant was in good condition and not disfigured by the instrument.

All the operations thus far reported as having been done in America have been successful in saving the mother, and three of the infants have been born alive. The fourth child might have been saved, it is believed, if the operation had been performed a few hours earlier. It is reported that a symphyseotomy performed at the Rotunda lying-in Hospital in Dublin, on Nov. 22d, resulted successfully as to both mother and child. The operation had not before been done there since 1782.—*N. Y. Med. Journal.*

Primitive Midwifery.—Obstetrics in Honduras, according to Dr. Philip M. Jones, *Brooklyn Med. Jour.*, presents peculiar features: The woman is generally unmarried—marriage is not quite so rare in this country as it is reported to be in Heaven, but there is sufficient rarity about it to suggest the comparison—and anywhere from twelve years old up. Picture to yourself a house about twelve feet square, with walls of sticks, plastered with mud, dirt floor, and thatched roof, all inside covered with a more or less thick layer of soot, grass, and dirt, the accumulations of the months or years that have elapsed since the "house" was built. No window and but one door, which is always tightly shut during the confinement, though whether to keep out the air or keep in the varied collection of nauseous smells is uncertain. On three sides of the room are boards supported by wooden frames, and on one of these luxurious beds, or more often upon the floor, is the temporary "lerain," her only article of attire being a cloth twisted up into a cord and tied as tightly around her body, just above the abdominal tumor, as the midwife is capable of putting it. Sitting or standing about the room are from five to twenty women, interested spectators, smoking and talking, and occasionally squeezing the patient's abdomen in order to expedite matters. They go so far as to sit on the patient, not metaphorically, but actually. The only light comes from a tallow candle slightly reinforced, if it be in the daytime, by a few struggling rays that creep in through the cracks in the roof and around the door, and seem lost in the prevailing atmosphere of smoke and a combination of smells which beggers description. Presently there is an unusually loud howl from the victim, a gush of the escaping waters followed, during the same or the next pain, by the advent of the child, who now sets up his wail, which adds a little to the weirdness of the scene. A red-hot piece of iron is now produced from somewhere and the cord burned through. Then the child is taken in hand and immediately wrapped up in old rags, a small space only being left for air, and by means of which a most noxious mixture of oil and dirt is put into the poor helpless child's mouth. The mother lies quietly for a few moments, then the placenta is pulled out, she is wrapped up, and remains quiet for a day or so, after which she goes about her work as usual.—*Med. Standard.*

Gynæcology.

A New Operation for the Relief of Bleeding Fibroids.—Dr. F. B. Robinson, *K. C. Med. Index*, describes an operation devised by Dr. Franklin H. Martin, which has proved successful in both cases on which it was performed. The patient is anæsthetized, placed on her back, and the uterus drawn down by a ligature passed through the cervix. An incision an inch long is made in the fornix on one side, the finger inserted into the tissue of the broad ligament when the uterine artery can be felt. The tissues are pushed away from the uterus toward the pelvic wall sufficiently to allow of a ligature being passed around the main stem of the artery. A curved needle is used to pass the ligature, and as the field of operation is well in sight the ureter can be avoided without great difficulty. The wound is closed by sutures, and a similar operation made on the other side. As soon as the ligature is tied the corresponding half of the cervix becomes pale and the pulsation ceases.

Ophthalmology.

The Mydriatics in Ophthalmology.—The following practical points in relation to the use of mydriatics we have taken from a clinical lecture, published in the *University Medical Magazine*, recently delivered at the Philadelphia Polyclinic, by S. D. Risley, M. D., Professor of Ophthalmology, in which he says:

Before entering upon the use of mydriatics for the purpose of paralyzing the accommodation, in the correction of errors of refraction, I call your attention to their employment during and after middle life. There is a widespread opposition to their employment after the age of forty, since it is during the middle period of life that glaucoma usually occurs. I am sure that the fears upon which the opposition is based are not well founded if due caution is exercised on the lines I have already pointed out. It is quite as important between forty and fifty years of age to use these drugs for the satisfactory correction of many eyes as before this period of life. The cases of retinochoroidal irritation, and accommodation cramp with tonic contraction of the iris and ciliary muscle, are quite as frequent as before the age of forty, and the therapeutic value of the mydriatics is just as marked. A wide experience fully justifies this statement. I have used these drugs with impunity, both in private and public practice in many thousands of eyes after the time of life specified. If harm comes from them it is because a sufficiently careful study of the case has not preceded their use. I have yet to meet the first instance of an acute glaucoma precipitated by the employment of a mydriatic, but I have always exercised the caution which I have pointed out, and again emphasize as the duty of every person essaying their use.

There is a widespread notion among the laity that the avoidance of reading glasses as long as possible is to save their eyes; that the necessity for a glass to read or work with is a sign of failing vision. They should be taught that the diminishing range of accommodation is physiological, not pathological, and it is not only useless but harmful to resist it. This working without a glass to correct the presbyopia is a source of much harm to the eyes and the cause of much suffering. I have, in a very large number of persons, seen violent headache and other reflex symptoms disappear as soon as a proper reading glass was secured.

The headache of old people is very frequently due to the eye strain brought about by the use of too

weak glasses, or from the neglect of astigmatic corrections. It is true, they have lost the power of adjustment through the hardening of the lenses, but they have not lost the ciliary muscle, and the fruitless strain to see with an improper glass is quite as painful and often as harmful to the eyes as earlier in life. It is in these cases you will find the solutions of homatropine of signal service. It should be used in from iv to viij grain solution three times daily until the ocular irritation subsides, and then the proper glasses chosen.

It is in young eyes, however, that the use of these drugs is most frequently needful. I wish to impress upon you, however, that they are not to be employed for the sole purpose of paralyzing the power of accommodation. This is of great importance, and in most cases a necessity if you are not to be satisfied with more or less close approximations in ordering the correcting glasses. My purpose has always been to determine with the greatest possible accuracy the static refraction of each eye. Having ascertained this, it may be used in any way the judgment of the surgeon may dictate; but until this knowledge has been gained all subsequent action must be based upon unknown factors, and this knowledge cannot be had except through measurements made after thorough paralysis of the accommodation.—*Med. Summary.*

Eye Lesions from Cholera.—Dr. Zapolski Downar of Lublin, Poland, calls (*St. Louis "Med and Surg. Jour."*) attention to the fact that in cholera cases which pass into the typhoid stage, there supervenes a total anæsthesia of the cornea, no reflex phenomena being induced either by touching the structure with a finger or by flies which manage to get access to the patient's open eyes. In the absence of appropriate precautions, such patients are very liable to contract corneal ulceration, the process being due to local irritation by dust and flies, as well as to the agency of some microbes present in the dust or introduced by the insects. According to his observations (he saw scores of such cases during the recent epidemic of cholera), the ulcers mostly attack the lower segment of the cornea, and then have either oblong or arcuate outlines. Occasionally, however, they are situated in the central area of the membrane, assuming a circular form, and sometimes penetrating deep into the proper tissue of the cornea. In four cases of the latter category the ulcer involved Descemet's membrane, while in two hypopyon was present, and in one prolapse of the iris (through a corneal perforation) occurred. To prevent the complication, he recommends: A systematic instillation into the conjunctival sac of a 1 to 6,000 aqueous solution of corrosive sublimate, and the protection of the patient's eyes from flies by a gauze bandage. As soon as the ulceration is noticed the lesion should be cleansed by irrigation, and the following ointment applied:

℞ Hydrargyri præcipitati flav.....gr. ij.
Vaselini..... ℥ ij.

M. et fiat unguentum. D. S. Introduce a bit of the salve (by means of a narrow strip of thin paper) beneath the upper eyelid, after which make a gentle massage (through the eyelid, of course) by means of a finger, or a piece of cotton wool.

The lesion rapidly heals, leaving some opacity, which subsequently disappears under the same treatment. In deep central ulcers with hypopyon, warm compresses, soaked in the said corrosive sublimate lotion, should be applied, and a 1 to 500 aqueous solution of blue pyoktina instilled into the eye.—*Med. Standard.*

Toxicology.

Deaths Under Anæsthetics.—Gurlt reported to the last Surgical Congress at Berlin, the following statistics of deaths under anæsthetics. They are made up from the observations of 62 operators, who anæsthetized 109,106 persons, with 39 fatal results, showing a death to 2,800 narcoses. The following were the anæsthetics used:

Chloroform	94,123	narcoses,	36 deaths
Ether	9,431	"	no deaths.
Ether and chloroform	2,891	"	1 death.
Ether and alcohol	1,381	"	no deaths.
Bromoform with ethyl brom.	2,151	"	1 death.
Penthal	210	"	1 death.

In 2,913 cases the narcoses lasted over an hour; in an operation for utero-vaginal fistula, 4½ hours; in a case of tetanus, 9 hours. In 25 cases, of which post-mortem examinations were made, carciac diseases were found. The author urges careful examination of the heart before administering chloroform.—*Cond. Extracts.*

Poisoning.—Sticker (*Centl. f. Med.*) says that in certain cases of poisoning, "the antagonism of certain drugs cannot be doubted, and the want of general recognition of the fact is due to the few opportunities of observing it. Thus, the unpleasant effects of morphine used as a hypnotic may be prevented by the addition of atropine. In some cases morphine produces excitement, and if it is still necessary to use it, atropine will antagonize this. A subcutaneous injection of morphine lessens considerably the dilatation of the pupil produced by atropine drops, and an injection of morphine and atropine combined produces only a slight dilatation of the pupil. Irritation of the skin sometimes produced by morphine is prevented by atropine. The diaphoretic effects of morphine are sometimes troublesome; they do not occur if atropine is added. On the other hand, the dryness of the skin produced by atropine is remedied by morphine. One of the effects of morphine sometimes seen, and especially in those cases attended with early paralysis of the bladder, as in tabes, is retention of the urine. Belladonna antagonizes it. Morphine mostly constipates; atropine has the opposite effect, especially in chronic constipation. In biliary and renal colic the two drugs should be combined.

Physiology.

An Experiment in a New-Born Child in Regard to the Location of the Respiratory Center (*Wien. Klin Woch.* By Prof. Kehrn). It became necessary to perforate in a primipara. After the head was opened the brain was broken up and partly washed out, partly pressed out by the pulling of the head through the narrow opening. Contrary to expectation the child breathed after being delivered. For a quarter of an hour it took deep, regular inspirations, six to the minute. The hand and foot reflexes were present, but no spontaneous movements of extremities. On looking into the cranial cavity it was seen that all the cerebrum and most of the cerebellum was gone. Only portions of the peduncles of the cerebellum and the pons remained, but the medulla re-

mained intact. The medulla was now cut across one centimeter above the point of the calamus scriptorius. No change occurred in respiration or reflexes. On another section being made one centimeter deeper, just at the lower end of the calamus, both respiration and reflexes ceased.

In the portion of the medulla isolated by the two sections there was contained neither the classical centers of respiration nor the roots of the important sensitive and motor nerves which have to do with respiration. One must therefore conclude that the respiratory centers lie in the same places in man as in the other mammalia which have up to the present time been used for experimentation.—*Am. Prac. and News.*

Pathology.

Tuberculous Ulcers of the Stomach.—Musser (J. H.) has made the following conclusions:

(1) Tuberculous ulceration of the stomach is rare.

(2) It occurs more frequently in children.

(3) It is never primary.

(4) Gastric infection is probably due to the voluntary or involuntary swallowing of sputum.

(5) The presence of the bacillus tuberculosis is the only positive proof of the nature of the ulceration.

(6) The anatomical peculiarities of this form of ulceration include the following:

(*a*) The seat of the ulcer is in the lesser curvature, although it may be found in any position.

(*b*) More than one ulcer is usually seen.

(*c*) The ulcers are large and irregular.

(*d*) Miliary tubercles on the floor of the ulcer in the submucous coat are seen.

(*e*) The ulcers are near vessels, and the results of valcular ulceration are found.

(*f*) Small caseating masses are seen in the ulcer or at a portion of the periphery. Similar collections are found in the territory adjacent to the ulcer, in the submucous coat.

(*g*) The peritoneum is studded with miliary tubercles very often.

(*h*) Neighboring lymphatics are often involved.

(7) In the large majority of cases there were no symptoms during life.

(8) Sudden hæmorrhage is a frequent symptom and cause of death; it has been particularly noted in children.

(9) Epigastric pain and vomiting may occur.

(10) The presence of gastric symptoms of this kind, occurring in the course of tuberculosis, is significant of possible ulceration.

(11) In view of the fact that the swallowing of sputum is possibly dangerous, expectoration should be insisted upon in adults, and its method taught to children.—*English Medical Press.* — *Canada Practitioner.*

Rhinology.

Abscess of the Nasal Septum.—Dr. Edward J. Bermingham, Surgeon to the New York Throat and Nose Infirmary, contributes an article on this subject, with the report of a very interesting case. A boy, eleven years of age, fell on the pavement, striking on his face. No symptoms beyond slight cutaneous abrasions were noticed for ten days, when the nostrils became occluded, and headache and frontal pain became almost unbearable. Four days later, when first seen, a tumor, looking like an inflamed polypus, presented through each nostril. Incision released a teaspoonful of thick pus and gave immediate relief to all symptoms. Aftertreatment consisted of thoroughly cleansing several times daily with a mixture of one part of glycothymoline to three of water. Recovery followed promptly.—*Medical Age.*

A Plea for Cleanliness in the Treatment of Naso Pharyngeal Catarrh.—This is the title of a paper by Dr. Edward J. Bermingham, Surgeon-in-Chief to the New York Throat and Nose Infirmary, in which he lays stress upon the importance of cleansing the nasal cavities from one to three times daily after any existing stenosis has been relieved, and during the employment of topical medication by the surgeon. If the parts are not cleansed the medication does not reach the diseased mucous membrane, and treatment will be disappointing. Proper cleansing with an alkaline, antiseptic, nonirritating, and deodorizing solution will alone cure fifty per cent of cases of simple hypertrophic catarrh and will benefit atrophic cases. The writer gives preference to a twenty-five per cent solution of glyco-thymoline as a cleansing fluid. He condemns the old time douche and all those where any force is used, and advises that the fluid be introduced through a small glass douche devised by him, which allows the fluid to gravitate slowly to the nasopharynx. Here it should be kept in contact with the parts for a minute or two before the nose and throat are cleared.—*New York Medical Journal.*

Materia Medica.

Ethyl Bromide.—Drs. E. Q. Thornton and E. Meixell conclude ("Satellite") that the dominant action of ethyl bromide is on the respiratory, not on the circulatory, system. The depressant effect exercised upon respiration is only marked when large and practically excessive doses are used. When cardiac failure ensues, it follows the presence of continuous asphyxia, and the pulse-waves and the failure is rather the result of imperfect aëration of the blood than of a direct action on the heart. Death from prolonged continuous use of ethyl bromide only occurred from respiratory failure. In one instance the heart continued to beat for several minutes after respiration ceased. In another instance for two minutes and some seconds after respiration. No exception was found to this result. In all experiments there was a slowing of the pulse, with an increase, rather than a decrease, in size of the individual pulse-wave. Associated with this pulse-slowing there was temporary slight fall of pressure, which was permanent, and increased if the drug were strongly pushed continuously. This change did not occur as a permanent one, however, unless the drug also caused asphyxia, with corresponding respiratory failure.

As far as can be determined, the cardiac depression is due to the blood changes, not to an action of the drug on the heart. By a process of exclusion, it would seem probable that slowing of the pulse is due to stimulation of the pneumogastric or inhibitory cardiac nerves. This probability was confirmed by finding that the slowing is abolished almost entirely by section of these nerves. If they be cut previous to the administration of the drug the slowing does not occur,

or is very slight. In some instances, however, slight slowing followed each consecutive use of the anæsthetic, even after the nerves were cut. In no case was there a sudden failure of respiration, and it was noted that the respiration might gradually cease entirely, and, after a short time, start up again if the amount given had not been excessive. This is probably due to the exceedingly fleeting action of the drug, which is the most volatile of the anæsthetics usually employed. Ethyl bromide has the advantage of not irritating the upper respiratory tract, and of being very volatile. Ethyl bromide is a safe anæsthetic for minor or brief operations, and for the relief of the pains of labor, since its effects are exercised so rapidly that a pain is abolished, yet the patient returns to consciousness at once without the drunkenness which prevents her from obeying the directions of the obstetrician.—*Med. Standard.*

Diseases of Children.

A NEW METHOD FOR THE TREATMENT OF ASPHYXIA NEONATORUM.—Laborde (*La Tribune Méd.*, Oct. 6) reports two cases of asphyxia, a woman, aged thirty, and her child of eight years, who had been for some time in the water, and who showed no signs of life. They were restored by Fourès, who used the process of Laborde, called by him "procedure of the tongue," and communicated to the Academy at the séance of July 3, 1892. It is applicable to any form of asphyxia, as by drowning, noxious gases, anæsthetics, or the asphyxia of the new-born infant. The process consists in opening the mouth, seizing the tongue, and not only drawing it forward once, but in repeating the traction successfully, and in rhythm synchronous with respiratory movements. This may be accomplished by the use of forceps, or by placing the finger in the throat back of the base of the tongue.

He reports (*Ibid.*, Nov. 24, 1892) a new and successful application of this method in the treatment of asphyxia by sewer gas, in one case succeeding where no other methods were of any avail, frictions, slapping with wet towels and Sylvester's method of artificial respiration having failed; and in another case being required after these had made an apparent success, followed by a relapse that resisted treatment by these methods. He also reported success in a case of simple syncope.

Laborde (*Ibid.*, Dec. 1, 1892) reports the successful application of his method by Pérrone to the asphyxia of the newborn infant. The labor was natural except for energetic and prolonged uterine contractions; the child was born apparently dead; no pulsation in the cord. Two years previously, in the case of the same mother, death of the infant occurred despite all efforts; he applied the method of Laborde, using a pair of dressing forceps; after a few tractions the child breathed; other means were simultaneously employed after this, and the child lived and is well and healthy. In two other cases where the children showed no signs of life, Pérrone has used this method with success.

The process is simple, of universal application, endangers the patient in no respect, and is highly recommended to obstetricians.—*Annals Gyn. and Paed.*

TRACHEOTOMY IN AN INFANT THREE DAYS OLD.—The *Lancet* contains the following interesting history: The case was an infant (female) three days old, well nourished, and weighing six pounds six ounces. The lower jaw was markedly receding and ill-developed, giving to the face the appearance of being "overhung." The tongue was very short, and there was a large cleft in the palate. The infant was cyanosed from birth and had recurrent attacks of inspiratory dyspnœa with great increase of cyanosis. These exacerbations usually passed off in a few minutes. On the evening of the 10th (eighty-three hours after birth) the condition suddenly became worse, with great lividity of lips, cold extremities and general collapse. The short tongue was with difficulty drawn forward, but without giving relief, and an unsuccessful attempt was made to pass a catheter into the air passage. The patient was evidently dying, and tracheotomy—as the only possible means of saving life—was decided upon. With the assistance of Dr. Tate, who also administered chloroform, Mr. Heelas proceeded with the operation, which was completed without any serious difficulty. The cricoid could easily be made out beneath the skin. The opening in the trachea was made below the isthmus and the smallest sized India-rubber tube, cut short, was provisionally inserted. The breathing immediately became quiet, regular and normal, the natural color returning to the lips. The child slept well the same night and took nourishment fairly well; but, the cleft palate preventing suction, it had to be fed by a spoon on peptonized cow's milk. On the 14th a Parker's No. 1 silver tube was substituted; there was no difficulty in its introduction and it gave rise to no irritation. The wound healed well. Respiration through the natural passage was attempted every day by closing the wound with the finger; it was found that the child could easily expire and cry out, but failed completely in inspiration. The patient continued to do well till December 2d, when it was seized with convulsions and vomiting, became rapidly worse, and died on the 3d—viz., the twenty-third day after operation. With one exception (on November 14th, when there was slight blood-stained mucus, owing to there being a little difficulty in reintroducing the tube after it had been left out for some time), there had not been any sign of tracheal irritation caused by the tube, nor was there ever any serious embarrassment in breathing.

At the necropsy, made twenty-six hours after death, on opening the thorax about three ounces of pus were found in the right pleural cavity, and there was slight consolidation of the lung on this side. The trachea was healthy, with the exception of a small spot opposite the situation of the lower end of the tube, where there was quite a superficial erosion. The tongue was very short, but broad and thick; and it was noticed that, by falling back on the epiglottis, the obstruction to the passage of air would probably have been easily produced.

Remarks.—In this case the operation was performed for a mechanical obstruction to the breathing, which was considered to be caused by the short malformed tongue falling back on the epiglottis and thus closing the upper aperture of the larynx. By means of careful nursing the child lived for twenty-three days, during which time the general health was good up to twenty-four hours before death, when symptoms of pneumonia developed. This complication was regrettable, as there was good reason to hope that as the parts developed the condition which necessitated the operation might have passed off.

Chemistry.

A NEW CHEMICAL REAGENT TO TEST SUGAR IN URINE.—A. Baeyer found in examining the artificial formation of indigo, that this preparation is formed by warming an alkaline solution of o-nitro-phenyl-propiolic acid with reducing agents.

G. Hoppe-Seyler uses this reagent to test sugar in urine. For this purpose he mixed 5cc equal 1 teaspoon of the alkaline solution with 10–15 drops of the urine to be tested and boils the whole half a minute. When the liquid turns a dark blue color, the presence of reducing agents, as sugar, is determined. Normal urine does not change its color, at the most it assumes a somewhat greenish color. Albuminous urine may also be tested in the same manner; the liquid undergoes no change, if the urine is mixed with acetic acid, in testing for the presence of albuminoids. This reaction has many advantages over others of the same kind:

(a) A solution of o-nitro-phenyl-propiolic acid is always ready to use and is a very reliable reagent.

(b) The reaction may be affected with a very small quantity of urine.

(c) The reaction is not interfered with by the presence of albuminoids.—*Zeitschrift für Physiologische Chemie, R. I. Med. Sc. Mon.*

BOOK REVIEWS.

"Manual of Practical Medical and Physiological Chemistry." By Chas. Pellew, E. M., Demonstrator of Physics and Chemistry in the College of Physicians and Surgeons, Medical Department of Columbia College. New York; Honorary Assistant in Chemistry at the School of Mines, Columbia College, etc. With Illustrations. D. Appleton & Co., New York.

The author of this work in visiting or interrogating some of the leading medical colleges both in this country and abroad, found that in every case where practical instruction in chemistry was given, it amounted to little more than urine analysis, with sometimes a little toxicology, consisting of a regular course of qualitative and perhaps some quantitative analysis. This work comprises thirty lectures in which, as far as possible, every subject and every test has some bearing on the student's other work.

These lessons deal not only with true physiological chemistry, with the food-stuffs and their products of assimilation, and with the different fluids and tissues of the body, but particular attention has been paid to the latest clinical tests. The student will profit greatly by a careful study of the book as the explanation of its chapters is clearly and thoroughly given.

"The Anatomy of the Peritoneum." By Franklin Dexter, M.D., Assistant Demonstrator of Anatomy of the College of Physicians and Surgeons. New York. With Thirty-eight Illustrations. New York: D. Appleton & Co. 1892.

Dr. Dexter, in his preface states that from his experience in the dissecting room, there appears no part of anatomy which is quite so unsatisfactory or incomprehensible to the student as the peritoneum. A clear idea of this important membrane and of its connection with various organs can only be had through a knowledge of its development, and for this reason this little pamphlet has been offered to the medical student in the hopes that by a perusal of its pages and examination of the sketches it may prove of value to him.

"A Pocket Medical Dictionary," giving the Pronunciation and Definition of about 12,000 of the Principal Words used in Medicine and the Collateral Sciences. By Geo. M. Gould, A. M., M. D. Philadelphia: P. Blakison, Son & Co., 1892.

This little book, soft, flexible and durable, is intended for a pocket dictionary, being a condensation of an excellent work, which has already found favor among medical men. It has been prepared upon the same practical, systematic plan as the larger book, and is based upon the most recent medical literature. It contains complete tables of the arteries, muscles, nerves, bacteria, bacilli, micrococci, spirilli and the mometric scales, and a dose list of drugs and their preparations, in both English and metric systems of weights and measures.

"Treatise on Diseases of the Nose and Its Accessory Cavities." By Greenville Macdonald, M. D., London, Physician to the Hospital for Diseases of the Throat. Second Edition. New York: Macmillan & Co. 1892.

The fact that this second edition follows in about twelve months after the first is sufficient of itself to indicate the great need of such a work. Several additions have been made in this late volume, among the more important being articles on croupous rhinitis and cysts of the middle turbinated bone. Much has been rewritten on asthma and nasal diseases, while an article on idiopathic rhinorrhœa has been added to the chapter on nasal neuroses. Many new illustrations will be found, and in fact the whole work has undergone a careful revision.

Pamphlets and Reprints.

Abscess Around the Rectum. By Charles B. Kelsey, M. D. Reprinted from the *Therapeutic Gazette.*

New Journals.

Food, which began life as a lay magazine, devoted to food and its proper preparation, has, with the first number of its third volume, become a medical journal, giving most prominence to hygiene and nutrition. The editor, Dr. Frank A. Woodbury, has the leading article, and others are contributed by Dr. J. V. Shoemaker, Prof. Tarnier, Dr. H. A. Hare and Prof. J. M. Da Costa. Probably no subject of as much importance in the practice of medicine is so little taught and written about as diet in disease. *Food* has a wide field of usefulness before it, and if the high standard of this issue is maintained it will build up a clientele of the best element of the profession.

MISCELLANEOUS.

ADVICE TO STUDENTS.—Dr. Robert Reyburn, *Jour. Am. Med. As.*, gives the following pertinent advice to the students of this country: I would say to American students that it is entirely unnecessary for those who desire to study the principles of aseptic surgery to go to Europe at all. At the German Hospital, the Roosevelt Hospital, the Polyclinic and others in the city of New York, and at the principal hospitals of Philadelphia, Chicago, Baltimore, Washington, etc., aseptic surgery is taught and practiced as perfectly as it can be found anywhere in the world. If American students desire the culture that only travel can give, by all means let them go to Europe; if they desire

boundless wealth of material for clinical study, let them go to London, Vienna or Berlin; but if they desire, besides these advantages, to see fineness of technique in carrying out the principles of aseptic surgery, my advice to them would be to go to Paris and study there. I am very certain they will never regret their choice.

TITLE.—M. Franklin has also something to say on the question of titles. He points out that the title of "doctor" is not met with earlier than the fifteenth century; up to that time the recognized title was that of "Master in Medicine" and "Master Regent" in the case of academic teachers.

With regard to inaugural thesis, M. Franklin states that the first mention of them occurs in 1395, though it was not till February 17, 1589, that a thesis was printed for the first time. The titles of these old dissertations are often interesting as reflecting the form and movement of the medicine of the time. Thus we found such questions discussed as, Is the Necessity of Death Innate (1572)? Is Air More Necessary than Food and Drink (1589)? Should a Lovesick Girl be Bled (1639)? In 1576 a precursor of Mr. Romanes debated whether the fœtus resembled the father more than the mother; in 1622 a thesis was presented on the superior wholesomeness of water as compared with wine; and in 1643, by way probably of reëstablishing the equilibrium of opinion, one bearing the unedifying title, Is it Wholesome to get Drunk once a Month? A bold bad man in 1646 argued that woman was an imperfect work of Nature. Canon Harford and the St. Cecilia Guild will be interested to hear that the question, Is Music Efficacious in Diseases? was propounded in 1624. Is Libertinism a Cause of Baldness? is a question asked in 1662, which is hoped, for the credit of a considerable proportion of the *jeunesse dorne* of the present day, was answered in the negative. Such a title as Ought Literary Men to Marry (1745)? shows that Mr. Andrew Lang was not the first to discuss this interesting question. The history of medicine, or, at any rate, of the revolution of medical opinion, in the course of the last three or four centuries, might almost be written from the titles of the inaugural dissertations presented during the period.—From the Review of "La Vie Privée d'autrefois," in the *British Medical Journal.*

ITEMS.

A monument to Dr. Marion Sims is to be erected in Central Park, New York.

Dr. H. C. Wood says quinine is contraindicated in chronic diarrhœa, gastro-intestinal catarrh, cystitis and allied conditions because of its tendency to irritate.

Dr. NORVIN GREEN, President of the Western Union Telegraph Company, who died at Louisville, Ky., on the 13th inst., was indicted for body snatching in Carroll Co., Ky., in 1840.

M. Taine, the eminent French author, who died recently in Paris, received an injection of "Brown-Sequard's elixir" when in extremis, from the effects of which he manifested a decided though temporary improvement.

MORRIS, of New York, (*American Journal of Obstetrics*, December, 1892) describes the clitoris as "a little electric button." That's right! In the language of the kodakers, when a man "presses the button" the woman "does the rest."

Howitz, of Copenhagen, reports success in treating a case of myxœdema by the use of a calf's thyroid gland as food. The gland was cleaned, cooked, hashed, and made into a paste with the water in which it had been cooked. Four lobes a day were given at first, and later, two lobes every other day. Improvement was noted in three days. An attack of urticaria occurred whenever the gland was taken. Vermehren has taken the glycerine extract of the gland, precipitated it with alcohol, and given the precipitate in pill, in doses of two to five grains; obtaining effects identical with those of Howitz.

Dr. SHLAPOBERSKI has found the caustic action of nitrate of silver in contact with iodoform, which it decomposes with a hissing noise, very efficacious in the treatment of lupus. In an obstinate case he scraped away all the large nodules and applied nitrate of silver, afterward covering the parts with collodion containing ten per cent of iodoform. The treatment was renewed daily. In three months there was a decided improvement, and in seven months the parts were entirely healed. There has since been no reoccurence though more than four years have elapsed. —*London Lancet.*

CHOLERA ABROAD.—Late reports from Hamburg, Berlin, St. Petersburg, and other European cities where cholera prevailed last summer, are to the effect that the disease still persists, and every effort is being made to prevent its rapid spread during the coming season. New cases are reported from Hamburg almost daily, and the emperor has directed that daily reports shall be made showing the progress of the disease throughout Germany. The Russian government has summoned a congress of 300 physicians, more than half the number being from infected districts. The congress will sit for a period of eight days, and a report is expected covering the best means of preventing the reappearance of the disease in the Czar's dominions.

WIT AND HUMOR.

A LUNATIC WIT.—A famous surgeon went once to see a lunatic in a private asylum, and in passing through a corridor, he was thus accosted by one of the patients: "Take off your hat, sir!" "Why should I?" he asked. "Because I am the son of the Emperor of the French." "Oh, I beg your Royal Highness' pardon," apologized my friend, taking his hat off. On revisiting the asylum a month or so later he was again accosted in the same corridor by the son of the Emperor of the French, and in the same words: "Take off your hat, sir." "Why?" asked my friend. "Because I am the son of the Emperor of Germany." "Surely, when last I had the honor to see your Royal Highness you were the son of the Emperor of the French?" "Ah, yes," he added, "That was by another mother."

Homœopathic.—Gwendolyn Eeversleigh laid her throbbing brow against the pane. She was a believer in Homœopathy. Pane vs. pain!

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

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ORIGINAL ARTICLES.

An Abstract of the Rational Treatment of Drink Habit Cases.

BY JOHN G. REED, M. D., CINCINNATI, OHIO.

The object of treatment is to correct bodily conditions that create affinity for stimulants and thus destroy appetite. The secondary object is to free the system of organic alcoholic disease, when such disease exists, and in all cases to produce complete restitution from strong drink by creating a positive physical and mental antidrink state. With this object in view and the case before me (signifying a desire to be free from desire for alcoholic stimulants and if unable to look after his treatment is willing to aid in procuring some one to do it for him) I proceed to diagnose his case, always careful to get full effect of the kind of psychic treatment best adapted to meet his case as we would or should in the management of all cases of sickness. By noting carefully objective appearances you will by a little practice be able to follow with accuracy a line of interrogatories that will bring out all salient points of the case, remembering that in those that have alcoholic affinity the disease of the drink habit begins with the first drink. Cases are either in the tippling or primary stage; the stage of habitual drunkenness primarily, or second stage, or in tertiary stage characterized by alcoholic organic disease and physical decline. The age of the patient, the constitutional history, the duration of his drunkenness, the duration of sprees and their change in periodicity (or daily consumption of stimulants if a soak), the beverage most used, the severity of reaction from stimulants, the general and special spree states of the digestive organs, the character of alcoholic countenance and usually (if a wine or beer drinker the size of the abdomen and limbs) will tell in what stage of alcoholic disease the case is. For the purpose of statistical study and to intelligently advise on for the complete isolation of my case in his important bearings, I make a record upon blanks for the purpose headed, to wit: Name, post office, state and county, age, married or single, occupation, duration of habit, male or female, church affiliations, pertinent facts of habits, mental diseases and deaths of blood relatives, special inquiry into state of health and social disposition at the time the drink habit began, together with his reason, right or wrong, for drinking early and late, altogether gives me full diagnostic information of the first and second stage and prepares the way for special and accurate examination for alcoholic lesions in the third stage, or to make an estimate of physical damage done by strong drink. Cases are also divided into sthenic and asthenic, and subdivided for the purpose of full range of treatment into family history cases, having brought the case if necessary to a state of collected mind by special treatment adapted to his case. For guides I have the morbid physiological condition in the first and second stage, and the pathological or lesionary state in the third. In the first and second stages in sthenic cases, if much agitated, I give 1 3 of aromatic spirits of ammonia in water every three or four hours, and sometimes add three drops of tincture of aconite and eight to ten drops of tincture of digitalis if the heart action indicates it, for the first day or two. In these cases there is an acute sensibility or hyperæsthesia of the peripheral nerves, so much so that the patient goes about with a painful self-consciousness that would drive him to a darkened room to sleep if it were not that sleep is only obtained by partial exhaustion. Nightshade should be given to give the higher brain centers rest for some time. The painful tiredness of the lower limbs from exhaustion, sometime general, accompanied by alcoholic excitement in the sthenic for the first three to five days, is best controlled by antikamnia. The painful tiredness that prevents sleep is best treated by antikamnia in full doses at night. Antikamnia for pain as a rule, opium never, and chloral seldom is my rule. In mild cases bromides and other nervines having no unpleasant reaction, can be tried, and if tolerated by the stomach, will do good work. Preparations of peruvian bark when appetite or digestion is unsupported after the destruction of alcoholic biliousness, diarrhœa, or stomach congestion and intolerance of food, caused by recent spree.

Cases of this type trouble much about calamities that are purely imaginary and incidental to a depressing storm in the mind following a debauch. For such disturbances ammoniate of valerian should be used freely. The attack of spirituous drink has been directly upon nerve tissue and the damage done is in the ratio that alcoholization of the nerve molecules has forced a lower order of action than the physiological one accommodated to approximate systemic harmony only by the intervention of a constantly increasing supply in most cases. Looking to the recovery of physiological action, use electricity, nux vomica, and cold cautiously in extreme sthenic cases. With this kind of treatment and due attention to contingencies holding the case to the central idea of a cure of bodily disease, that will reconstruct his system so that he will not want to drink stimulants, will bring the case to a tolerable good state of restitution ordinarily at the end of a week. Considering the case at this period we will by practice soon learn to get an intuitive glimpse at the play of forces as the individual changes from the negative side of the drink line to the positive nondrink side of it. (Here let me say that no physician can succeed in the treatment of drink habit cases who cannot frame in his mind the approximate spiritual and physical state and bring himself in vibration with the case to soundly doctor and direct, any more than a Mohawk Indian with a knowledge of the multiplication table can teach successfully the fine arts.) At the end of the first week the case has crossed the drink line and the doctor has become a kind of a Moses to him. The patient shows in his walk personal pride, cheerful face, most of all in his happy thoughts, frank confession and more healthful consciousness (when denouncing the drink habit philosophy and his rapid adjustment under nondrink philosophy) that through the potency of medical and psychic treatment you have practically cured your case. But your patient must be steeled to the

new order of things by a continuance of treatment. The nux vomica or electricity and nightshade or antikamnia or in place of either of the two latter in case of very limited physical endurance, full doses of fluid extract of coca should be continued for a week longer and withdrawn during the third week of treatment; all depressing agents having been withdrawn from the second to the fifth day. The patient should continue to call at office daily and special treatment introduced. Unless it be stopped too soon it is best to fix an arbitrary limit for its use of ten days or two weeks. Let us first isolate the case at the end of the third week and examine his bearings before he is dismissed to continue convalescent or better prophylactic treatment without daily office calls and upon the word of his honor. So great is the contrast of his new compared with his old self, yet vivid in his mind that he will deem farther treatment superfluous. He does not realize he has been lifted out of his old self by powerful medical support and professional management, and if these are taken away suddenly and nothing substituted before he hardens into a positive antialcoholic state that he is liable to be put to a severe test, become negative, then bewildered and falling into a favorable current wake up some morning to realize that he has been on a drunk, the whys and wherefores of which being beyond his comprehension are very mortifying. The case is still within your grasp; indulge nothing but the serious with him. Frankly tell him the truth about himself. You will be astonished to see how the patient will learn from you, (at this period some cases are conscious of a weakness that they fear will prevent them from enduring on the higher plane of action,) while you point out to him that his new frame of mind and his memory of drink pain are great aids to him but that they cannot and will not save him from future drinking unless he takes medicines that will by vitalizing and harmonizing influences, give him the necessary physical support and coördination of energy to prevent the drink impulse or alcoholic affinity from returning. The danger of the majority of cases at this period is in the physiological error that created affinity originally and is the physical foundation for the drink habit.

Experience has demonstrated in my practice that the error is lack of coördination in physicial energy and is best controlled and cured by the administration of hypophosphates. Iron, chlorates and other medicines that can be used as these are for harmonizing purposes, selected, combined, and administered with proper digestions in doses suited to any given case. The habit of holding up cases at the beginning of the convalescent period with narcotics for the sake of manufacturing reputation is criminal and accounts for many violent and some fatal relapses, nitrate caffeine, had best be given the fourth week. If the patient is much nervous or disturbed in sleep, plenty of sleep must be secured. During the last two weeks alternative treatment should be given on general principles of practice for the removal of scrofulous, syphilitic or other materious morbi that may be apparent by the general history of the case. Hydrargerum iodides, arum, zincum and others compose a list from which to select an alterative best adapted to the case.

Ammonia disintegrates too rapidly to be used for these cases at this period except in the most sthenic. Mild alkalies and saline mineral waters should be given when adapted to remove some systemic error as in the case of acid diathesis, arthromita, or for special diuretic effect when indicated. Kumyss or better the Reed and Carnrick self-digesting Kumysgen powder is nowhere more valuable than in these cases of interrupted digestion.

The asthenic cases treated alike in the first and second stages require full supporting medical treatment from the first but upon the same general line of medication and management as already given. The bitter tonics, frequent electrical and hot baths, massage, regulated exercise, and much rest and sleep are important. Some of these cases belong to the neurotic family and are often peculiar and incorrigible for a time but once they are started right they make rapid recoveries. Among them is generally found a neurotic intellectual keenness that acts quickly when opportunity is understood. If their dispositions are not properly understood and managed they are likely to come into bad faith with you and resort to cunning greatly to their detriment. Many of them are hysterical and are best managed by the clever arts used to control this disease. An ignorant type of this class get well when treated and remain so while under your influence and management but they are without aspiration and are so at the mercy of the merciless when let go that their negative nature designed to always be negative yields to every wind that blows.

This class go down to vagrancy and become the pestiferous tramp of whom we see so much and know so little. The last class is the asthenic in the tertiary stage whose lesions are legion—organic alcoholism, waste of nerve tissue, with a breaking down of all physical powers. A distinct culminating condition of things, not alone a hot box and a burned flue, or a leak in the boiler with lime crusts interfering with the generation and distribution of caloric, but a rust-eaten condition of all the material of the machine, molecular adhesion weakened in every part. Every battery of physical force and medium of transmission is characterized by corroded elements and broken circuits. The once magnificent spiritualizing machine that contained elements that brought it in touch and approximate harmony with the universal life currents is shorn of its high potentiality and circumscribed to the insolated state of organic inebriety. Fixed under continuous drinking as much as if they had been born physical monstrosities, the whole physical economy is virtually an alcoholic lesion producing uniform results as a rule. We have either the twisted shrub or broken oak. The leaves are in the sear and there is decay at the heart. Nature will do no thing for these cases if they continue to drink but waiving consideration of loss by prodigality alcoholic or organic disease such as atheroma, liver disease and progressive paralysis when incurable if they are cured from desire for strong drink she will recover healthy action and will do as much for them as the capabilities within them will amount to if fully exercised.

True development begins where it was stopped by strong drink after tearing down the alcoholic construction. The matter of disintegrating and recovering healthy action is not a work of a few weeks, but of many months. These cases rapidly improve under the treatment outlined. My experience teaches that many of them should be kept under treatment or otherwise in touch with their doctor, for two to twelve months. Plenty of time should be asked for, and agreed upon, on receiving these cases. Good judgment should be used in withdrawing stimulants,

and in the use of remedies that increase waste. In this matter every case comes up upon its merits. In bad cases five or six days should elapse under supporting treatment that will support without using waste producing remedies farther than to arouse the liver and digestion with blue mass etc., and cleverly neutralize the stimulants taken from day to day, with aromatic spirits of ammonia. At the end of five days, or when digestion is fairly reëstablished, and the alcoholic storm has subsided, spirits mindirerus valerianate of ammonia and an occasional dose of Honiedia water if needed, to eliminate waste, should be given until the sluggish state of alcoholism is broken down. In these cases, the cadaverous "whiskey" countenance, and the large bellies of wine and beer drinkers will usually remain. When they disappear they are the last sign of dissipation to go. Fatty degeneration of muscular tissue, and increase of connective tissue are promptly checked, as a rule, by treatment. Exceptions should be made in some forms of heart disease.

So etherial must seem many of these features of diagnosis, management, and treatment, to those who cannot put themselves in vibration with drink habit cases, that I am disposed to say that he who learns to succeed in the treatment of drink habit must regard this subject as being as deep and broad as any other one, except the one of life as life; he must develop the positive antialcoholic constitution. Political, social, and creed hindrances to a proper understanding of this subject and healthy exercise of sympathy in disease must disappear, and there must come the doctrines of humanity to be practiced for humanity's sake, thereby causing interest in the subject of drink habit cases to transcend social ethics that oppose familiar associations with drinkers and drunkards.

Paranoia.

By Frank Parsons Norbury, M. D.

Assistant Physician Illinois Central Hospital for the Insane, Jacksonville; Formerly Assistant Physician Pennsylvania Institute for the Feeble Minded, Elwyn, Pa. Read before the Military Tract Medical Association at Canton, Ill., Oct. 17 and 18, 1892.

Paranoia is a term in clinical medicine, which has not been fully accepted in England, nor has it in our own country, been understood to that degree to warrant its acceptance in common parlance; it is a term used to define an essentially chronic form of mental disease, characterized by persistent sytematized delusions; more extensive than monomania, and including impulsive insanity, mild dementia and even simple chronic mania.

Kahlbaum was the first to apply the name paranoia, which Heinroth had created, that class of cases, now recognized as paranoia, which we have just defined. The psychosis is a degenerative one, depending on diseased state of an abnormally developed brain, congenital or acquired. It occurs always in persons "in whose brains there is the potentiality of mental or nervous diseases;" it is strongly hereditary insanity, and manifests itself in anomalies of the conceptional sphere, which, while they do not destructively involve the entire mental mechanism, dominate it. That is, there is a permanant undercurrent of perverted mental action peculiar to the individual, running like an unbroken thread through his whole mental life, obscured, it may be, for these patients are often able to correct and conceal their insane symptoms; but it nevertheless exists and it only requires friction on the surface to bring it to light. The general intellectual status of these patients, though rarely of a very high order is moderately fair, and often the mental powers are sufficient to keep the delusion under check for the practical purposes of life. While many of the patients are irritable, depressed and restless, yet the sole mental symptoms of typical cases of this disease consists of the fixed delusions. The change from normal mental state is slowly developed and most commonly in the direction of elevated ideas, exaggerated self-importance and persecution. Kiernan says, "since the subject matter of the delusion is of such a character that these patients consider themselves either the victim of a plot, or as unjustly deprived of certain rights and positions, or as narrowly observed by others, delusions of persecution are added to the fixed ideas, and his patient becomes sad, thoughtful or depressed in consequence. The patient is depressed, logically, so far as the train of his ideas is concerned, and his sadness and thoughtfulness have causes which he can explain and which are intimately allied with that peculiar faulty grouping of ideas which constitute the rendevous, as it were, of all the mental conceptions of the patient. Nay the process may be reversed; the patient beginning with a hypochondrical or hysterical state, imagines himself watched with no favorable eyes. Because he is watched, and made the subject of audible comments (hallucinatory or illusional) he concludes that he is a person of some importance. A case illustrating the foregoing evolution of a delusion has recently come come under my obervation: H. H., aged fifty-nine, admitted to Illinois Central Hospital for the Insane. Cause of insanity was unknown. A man of ordinary intelligence; good common school education, a great reader. For the past five years he has, at times, been very melancholy, depressed and inclined to be suspicious. The first indication of anything wrong was manifested in the fear he had of indictment for walking on a rail-road track; believing he had committed some crime against the government. He talked rationally on all the other subjects, and soon after admission was given parole privileges; he worked about the premises and assisted in the kitchens until he believed he was being watched by the employes and others. He thought they wanted to kill him, and to do this they poisoned his coffee; he refused to go out to the kitchen, and remained on the ward but here he imagined the patients talked about him, in *fact* they *did*, but not in the way he supposed. One day last August he came to my office, sat down, and then asked if he could not have sometning done for him. His story was briefly this: that he was a king, a king of the Masons, that he had been for five years or more; that he was sent here by the people to get rid of him and the U. S. government recognizing him as the King of the Masons, was going to persecute him and had been doing so. Said he felt safe here when he first came, for the government would consider him insane (although he was not) as long as he remained here, and would not persecute him but as he was granted the privileges of a sane man about the premises, the government employed the kitchen help to watch him,

to see that he did not escape and hired them on two occasions to poison him. When he refused to go back to the kitchen he found they had placed a usurper to the Masonic throne in the ward with him; this man, the new comer, claimed to be the king and said that he (H. H.) was merely "a petty forger." H. H. appealed to me to visit my fellow Masonic brethren and have the true king once more proclaimed king. He said if he lost his throne he would commit suicide as there was then nothing worth living for. He said he had been drugged by the men in his ward and other attempts had been made on his life. He wanted me to protect him. He was removed from the ward to another in the annex building where he now holds full sway as the Masonic King. He asks for no homage except from the Masons and is contented and happy, so long as he is not crossed. He was intelligent enough to conceal his delusion, in regard to being a king, for over five years and then only disclosed it, to protect himself from imagined injury and humiliation.

Now there are many paranoiacs at large; they are not all in the insane hospitals. You all, perhaps, have met one or more. Some great general excitement, as the present presidental campaign, brings them forth; they throw themselves into the campaign either in a fixed character that they construct for themselves or as some influential personage. The paranoiac seeks interviews, holds conversation with the big men of the day, accepts the common courtesy shown him by those in office as of tribute to his value; is rejected, however, and then judges himself the victim of jealousy; makes querulous complaints to higher officials, perhaps makes violent attacks upon them and being incarcerated in a jail or asylum, looks upon this as the end of the long line of persecutions which have broken the power of a skilled diplomatist, a capable commander, a successful leader of men, a prince, a king, or the very Lord of Lords. All through this train of ideas there runs a chain of logic and inferences, in which there is no gap. If the inferences of the patient were based upon correctly observed facts and properly correlated with his actual surroundings, his conclusions would be perfectly correct.

To illustrate again the foregoing detailed symptoms, I will report the case of F. K., whom I have known from boyhood up. He is now an inmate of the Illinois Central Hospital for the Insane. At the age of 24, he became so insane as to require watching and then and then only, as in the case with most of the patients we receive, his friends thought him insane because he threatened the life of his brother. He was peculiar from boyhood, evidently had imperative conception as a boy, for while working in a shoeshop I have known him to do queer things; would leave his work and go home. Then while on the street if he saw one side of it was unoccupied he would cross to the unoccupied side, would avoid people and soon developed the idea that a certain individual was persecuting him. This idea, after twelve years, still persists. He was suspicious of this man and believes he drugged him. Since admission to the hospital he has shown the same systematized delusions of persecution and on several occasions has attempted escape because of these delusions, he gets depressed, refuses food and then again insist upon washing his hands after handling anything touched by others. He is a believer in his importance, has said he possessed great knowledge and on this account he is persecuted. He is now becoming slowly demented; his hair is prematurely gray, he looks old and is sinking into premature senility. I have known his family intimately, his father died a few years ago of old age, his mother died of cancer, he has a brother a confirmed inebriate, another a drinking man, and only two of the children are strong and well. While there is no other insanity in the family, there is neurotic and diathetic history, and as I have said paranoia is strongly hereditary, yet it is acquired as in this case. I should say it was due to abnormally developed brain, the result of hereditary physical degeneracy. In congenital cases we may notice an early and sudden outburst of symptoms which may go on to dementia or attain a certain degree of chronicity and there remain for years without apparent changes. Time tends to weaken the intensity of the delusions, and therefore, renders the patient less and less dangerous to society.

They are dangerous persons to be at large, for murder and persecution are their means of redress when they feel they are the victims of conspiracy or they feel called upon, through excessive vanity, to save the government, etc., at some supposed crisis in its history.

Guiteau was undoubtedly a paranoiac, likewise Daugherty, the killer of the physician at the Kings County, N. Y., Insane Hospital.

King Louis II., of Bavaria, was a paranoiac. Many of the families of royalty have paranoia as entailment of the heritage of Royalty.

Paranoiacs are often the projectors of great schemes of finance and sometimes successfully carry into operation such views. The inventors of perpetual motion are paranoiacs, and the excessive feeling of importance here creeps out in the description of their inventions. I have under my care such a case of paranoia. T. H., age 42, miner; native of England. Cause of insanity unknown. Very little known of his family history. Jn June, '83, became very melancholy; thought everybody was down on him because he was poor; he proposed a scheme to relieve himself and assist the poor.

He proposed to build houses on cheap land, and sell on installment plan; this was not a bad idea but the associated delusions caused his commitment to an insane hospital, viz.: that his friends had "gone back on him," that unless his scheme went through he must kill his wife and baby and then himself. As his buildings did not go up and no one interested themselves in his plans, he commenced to talk of retaliation and murder.

He has always been of a mechanical turn of mind, and his thoughts run on machines for perpetual motion, schemes for new naval machinery and ideas for combined locomotion on land and sea. If one listens attentively to his plans and schemes, he will reason, and logically too, out the plan he has in view, but should you make light of his ideas then comes forth the associated delusion of persecution.

I conversed with him just a few days ago with a view of getting him to prepare me a drawing for one of his perpetual motion machines, but his credulity was aroused as it has not been with me, before he said he believed I was wanting to make fun of him and he would not grant me the request. He further said all of his drawings were for the United States Navy Department and he could not stoop to make me a drawing to be used as a mere idle curiosity. No! he would

have me to understand that his ideas were beyond my conception, and until I could bring some one to him who could understand mechanics, and the laws of motion, he would not have anything to do with me. He has personal revengeful feelings against many of the hospital employes because of their inattention to him, the great inventor of perpetual motion.

Diagnosis.—The diagnosis of paranoia is based on the persistent systematized delusion. The study of paranoia offers for its consideration many of the most anomalous problems in psychology, since individuals whose minds are on some one point thoroughly deranged, may as regards other matters, not only manifest extraordinary energy and acuteness, but also, while admitting the peculiarity of, defend their abnormal suppositions, with arguments requiring for their exercise considerable logical acumen.

Fully competent to detect they may ridicule absurdities in others which are trivial in comparison with theirs. I have seen this time and time again on the wards of the hospital. They thus display much intelligence and discrimination.

Frequently they conceal the real condition of their own minds, rendering it in such cases difficult to conceive why a capability for the disposition of property, or responsibility for acts other than acts arising from the delusion, should not appertain to those so afflicted. "Such cases constitute the crucial tests of physical science."

In mental diseases and in this particular form in its early stages above all others, unusual difficulties demand increased care for their diagnosis. To make a proper diagnosis requires more than a mere visit where hastily a few questions are asked, and the recital of apparently anomalous facts are listened to.

Medical men without experience in insanity are prone to regard the appearance of peculiarities of conduct with too much indifference and also in their examination of cases to make a deliberate investigation, scrutinizing the individual character, the progress, order and combination of symptoms and their relations to the psychical and physical constitution. When as is often the case, crime has been committed, there is a demand for prosecution, which overrides the physician's judgment, and his hastily made examination reveals no insanity and forthwith another wrong is done to medico-legal science. To diagnose paranoia we must appreciate the various sources from which the elements of a just psychopathic opinion are derived. There are:

1. Study of the general and special relations of the individual affected.

2. Analysis of his mental and moral constitution in their mutual reactions.

3. The relation of the paranoiacal conception to the foregoing.

In the study of the individual following the outline just given we must bear in mind the fact that observation proves that to distinguish peculiarities and idiosyncrasies of feeling and thought which specially appertain to particular individuals, from similar conditions of feeling and thought which may in others be most valuable as denoting the presence of disease, requires successive observations of the individual that we may be sure the act or acts are of value as symptoms of disease.

It is not therefore sufficient that the medical man who would determine the question of soundness or unsoundness of mind be informed of special acts which he contrasts with what he may regard as an approved standard of mental health, but it is requisite that his standard be the admitted mental health of the individual, that the acts specified may have their value determined accordingly; since to quote the words of Dr. Gooch, "it is the prolonged departure, without adequate external cause, from the state of feeling and modes of thinking usual to the individual in health, that is the true feature of disorder in mind." Paranoia may exist for years and not be detected. It is possible for an individual to carry on the ordinary duties of life and with credit to himself and yet the greater portion of his life be under the most absurd delusions, which were concealed because special circumstances made this possible. Grave medico-legal considerations grow out of the acts of paranoiacs, hence the importance of diagnosis. It may be here remarked that crime has its analogy in some forms of paranoia. The first crime and the first paranoical supposition are steps toward the progressive giving way of mental stability. Crime is a vice, paranoia a disease. Their progress is mental. Perversion is similar and many times closely allied.

Prognosis.—The prognosis is unfavorable as regards recovery. Primary paranoia may be cured. Should a patient recover the chances are he will relapse and then go to dementia—the final end of most cases of paranoia. A great many cases find their way to the insane hospitals, where they live without much apparent change, from day to day. Terminal dementia claims many, and as intelligence is lost they become more or less stupid, careless, restless and untidy. Being a natural degeneracy the outlook from the first is toward dementia.

In conclusion, gentlemen, I would say that as physicians we can be of some assistance in the prevention of this form of mental diseases by giving words of advice to the young; urging correct habits of life, the study of heredity and the application of its laws in marriage. The insane diathesis breeds paranoia; it is its father and we can and will always have it with us, for if insanity should be blotted from the face of the earth to-day, ere to-morrow's sun went down insanity would appear again. Why? Because people do not live right; they live too fast and as a result we have decline and death. Insanity, and especially paranoia, is evidence of degenerate living and we can estimate paranoia by the hygienic and mental equilibrium of a nation.

Proceedings of Societies.

Gynæcological and Obstetrical Society, of Baltimore.

DECEMBER MEETING.

The President, Dr. B. B. Browne, in the chair.

Dr. Hunter Robb read an abstract of an article by Prof. Gusserow on "Ascites in Connection with Gynæcology."

In the Archiv für Gynæcologie for 1892, Professor A. Gusserow, of Berlin, has an interesting article on "Ascites in Connection with Gynæcology," of which the following is an abstract:

A high grade of ascites has often been observed occurring in connection with affections of the genital apparatus or of the peritoneum, which seem to occur

by preference in women. In these cases at first even the skilled diagnostician cannot say anything more than that he has a general ascites (nonencapsulated.) There is a lack of the symptoms which occur in ordinary ascites; there is no œdema in other parts, for instance, of the legs, the abdominal wall or of the outer genitals. A patient often comes to us like a skeleton with the exception of a very prominent abdomen, which makes us think at once of an abdominal tumor in the modern sense of the word, *i. e.*, a new growth. A special characteristic of this kind of case is the absence of all the ordinary factors, one or more of which are so often found to have given rise to ascites. So then in the first place, a careful examination must be made for disease of (1) the circulatory apparatus, (2) the liver, (3) the kidneys; and only those cases of ascites in which such etiological factors can be positively excluded, come properly speaking, into the domain of gynæcology; and it is only these and none others that Gusserow is discussing. Most gynæcologists are now agreed upon the best method of handling such cases. Unfortunately the ordinary practitioner is too apt to follow the older method, a circumstance which sometimes proves very unfortunate for the patient. He still clings to the idea that an attempt should be made to ascertain the cause of the ascites by means of a puncture, or what is worse, he is apt to make the treatment consist in further punctures and to continue these till the death of the patient. Puncture is in my opinion in every way inadvisable. It is true that we, in common with other gynæcologists, for many years taught that puncture was always necessary for the diagnosis for an abdominal tumor. This idea they have now given up, and we consider it quite as absurd to make a puncture for diagnosis in the cases of general or "free" ascites. This new doctrine I have taught for years and the same holds good for tapping to take away the greater part of the fluid. It used to be the custom to make a puncture with a Pravaz syringe, and draw off a little fluid, have it examined chemically and microscopically, in order to make a diagnosis of the kind of ascites and of its probable origin. Although much work has been done on the subject, there are many cases, and especially nearly all of these cases of "general ascites," which we are discussing now, where such an examination will give us no information at all. Better than this is tapping for the removal of the greater part of the fluid, since we thus get a better chance for palpation of the abdominal and pelvic organs, and may possibly be able to detect the cause which was concealed by the amount of the fluid. This chance of making a diagnosis frequently led to the adoption of this treatment, which as we said, was often not the best for the patient. The reasons against this method are: (1) the uncertainty of being able to make a diagnosis, even when the fluid is drawn off; (2) the faint chance, even with the best asepsis at our command, of setting up a septic process. (This latter danger has now, it is true, been reduced to a minimum, but we have nevertheless seen cases of erysipelas and of septic peritonitis from tapping;) (3) the liability of injuring vessels and of consequent internal bleeding; (4) the impossibility of drawing off all the fluid by tapping, and the almost certain return of the fluid which perhaps necessitates tapping again and again.

I have given up both the puncture and tapping and prefer to make an incision about 6 cm. long, then empty the abdomen of the fluid, and inserting the finger, find out what is the local cause. One is then at once able to decide for or against an immediate or a future operation. If a radical operation is not to be done, we have at any rate drawn off all the fluid. The cases are divided into groups. To the first group belong cases of "general" ascites as a consequence of so-called "tuberculous" peritonitis. This form appears mostly in young people. No lesion in the heart, kidneys or liver is demonstrable and no signs of tuberculosis are anywhere found. On laparotomy one finds numerous nodules of a gray, reddish color both on the visceral and parietal surface of the peritoneum. Some of these cases, as it seems to us, are not cases of tuberculous peritonitis in the modern acceptation of the term. We would prefer to call them cases of "peritonitis nodosa." The first case given was observed by me twenty years ago, before the tubercle bacillus was discovered. The patient was quite young, twenty years of age; no signs of phthisis. There was a high grade of ascites Patient had been tapped several times. Laparotomy was performed, the fluid evacuated and the before-mentioned nodules were found. Seeing the nodules I made a diagnosis of tuberculosis and gave a bad prognosis, and the patient got well. In the second case laparotomy was performed, the fluid was evacuated and one of the nodules cut out. The central portion of the nodule was caseous, but no giant cells were found. (Tubercle bacilli had not been discovered and were not looked for.) The patient recovered. The third case which was operated upon in 1892 was somewhat similar. The microscopical examination showed small celled proliferation with a rich blood supply. No giant cells, no tubercle bacilli. In any of these three cases tapping would have been of no avail, for it would not have been possible to make a diagnosis by palpation except by exclusion after the fluid was drawn off and the diagnosis could only be established by opening the abdomen and cutting out one of the nodules for examination.

The second group consists of cases where the ascites was due to papilloma of the ovaries.

Papilloma of the ovary, or superficial papilloma of the ovary consists of an abundant growth of connective tissues villi, which come from the surface of the ovary, while the ovarian stroma itself is either found to be thickened or is nearly normal. These cases are not always distinguished from those rare cases in which a papilloma has burst, and a part of it has grown free in the abdominal cavity. The characteristics of superficial papilloma of the ovary are, (1) both ovaries are generally involved, (2) they cause a high grade of ascites, which is liable to return again after tapping, (3) they are generally too small to be palpated, even after tapping. The first observation of this kind was published by myself and Eberth in Virchow's Archiv, No. 43, 1868. Patient, thirty-four years of age, had a high grade of ascites for a year and a quarter. Had been tapped several times (in Billroth's clinic among others.) No reason for ascites discovered. Umbilical hernia developed and burst, and the patient increased the opening herself and let off the fluid. Finally the hernia became very large. A convolution of intestine had come out through the hernia, and when the patient was seen most of the small intestine lay outside the abdomen and showed signs of discoloration. Operation for hernia. Rupture of gangrenous portion of intestine. Death. Post-mortem showed papilloma of the ovary.

(He also adds other cases.) These cases of rare disease of the ovary ought to convince us that where we have ascites from some unknown cause in the abdomen, we ought not to limit ourselves to puncture, in fact we ought not to puncture at all. In none of them was it possible to diagnosticate the nature of the cause till the abdomen had been opened. In one of them where puncture had been made before, and bloody serous fluid evacuated, we might have been led to think of carcinoma of the peritoneum and been unwilling to operate. This admixture of blood, as a matter of fact, was a result of the puncture. In two of the cases death unfortunately followed the operation, but this must be attributed to the exhaustion of the patient by the frequent tappings. In another case death was caused by septic peritonitis. Otherwise we feel sure that the patient would have been cured, since we have no instance of recurrent papilloma of the ovary where it has once been thoroughly excised.

To the third group belong those far more common cases of ascites due to carcinoma of the ovaries and the peritoneum. Here it might be asked, "Is not incision unnecessary? Here we can feel even a nodular tumor after puncture. Is it not sufficient to puncture in order to make the diagnosis?" However, again we should employ incision. First, because we can never be otherwise sure that the growth is cancerous. Secondly, because only by this means can we decide whether (if there is carcinoma) the ovary or uterus ought to be removed, as it is the rule to extirpate cancerous ovaries unless the peritoneum is involved; and every carcinoma must be removed, if it is in healthy tissue. If there is carcinoma of the ovaries, then by incision we can tell whether or not the peritoneum is affected, and that only can be discovered by laparotomy. It will be objected that in malignant disease laparotomy has sometimes hastened death. This by no means always occurs, and against it we can put first, the certainty of diagnosis; secondly, if the tumor is benign, a timely operation and recovery; and to these we may add that where the tumor is malignant, a laparotomy sometimes hinders its progress, and even without further operation, life is prolonged.

These cases fall naturally into three subdivisions, (1) those in which malignant growth could be removed (with ovaries). It must be remembered that we are not talking now of operations for malignant growths in the abdomen in general, but only of those in which general ascites is the characteristic symptom. Out of three cases two recovered completely, the third died later of multiple sarcomata. In the second subdivision come those cases in which the malignant growths could not be entirely removed. The first case has the following history: M. G., aged 20, admitted Aug. 18, 1891. Primipara. Three months before entrance she had a great deal of pain in the abdomen, which obliged her to stay in bed. Was in bed four weeks. Before entrance she noticed a swelling, with no pain, but shortness of breath. The abdomen measured 110 cm. General ascites. No tumor felt by palpation or vaginal examination. Laparotomy Aug. 18, four to six liters of ascitic fluid removed. Tumor size of fist on right side of uterus in layers of broad ligament. Mass adherent. Removed with difficulty because the tumor was of a friable, medullary material. A great deal of hæmorrhage followed. Left ovary healthy. Diagnosis, spindle and round cell sarcoma. Patient recovered from the operation, but died of peritonitis without ascites, and of marasmus after seven months. Autopsy, general sarcoma of peritoneum, omentum, retroperitoneal lymph glands and retro-sternal glands.

The next case, one of carcinoma not connected with the genital apparatus, but adherent to the intestines. Removed. Patient left hospital completely well. She was lost sight of. Of the five cases in this category, in all of which a portion of the growth was left in the abdomen, three died, not in consequence of the operation, but on account of the rapid development of the malignant growths. Two got well (one a woman of 75). What became of these cases ultimately is not known. Their lives were prolonged by laparotomy.

To the last subdivision belong those cases of ascites where no attempt was made to remove the tumor, but where the abdominal section was made for the sole purpose of evacuating the fluid; of five cases two died and three got better for the time being.

These cases may show that for drawing off the fluid laparotomy is often better than puncture. The fluid can be so much better removed in this way, a diagnosis can be made, and we know with absolute certainty whether an operation is indicated or not.

Lastly, we must mention cases of general ascites caused by benign disease of the genital apparatus. The first case was a woman, aged 57; 9 children; came into the clinic Aug. 4th, 1890. Menopause one year ago, since that time had remarked a swelling in the abdomen, which caused her no particular inconvenience. For the last three weeks, rapid increase in swelling, causing a feeling of tension, pain in abdomen and back, with pain on micturition and prolapsus vagina. Abdomen 103 cm. (from ascites). No tumor felt in abdomen, nothing discovered in the other organs. Laparotomy Aug. 6th, 1890. Color of fluid, yellow, hard tumor fastened to the left cornu of the uterus, easily separated from it. Right kidney a little out of place. The uterus was attached to abdominal wound. Tumor proved to be fibroma ovaril sinistri. Recovery. Vagina replaced. Even operation did not show the reason for so much ascites.

By tapping, of course, we could not have discovered the real nature of the tumor causing the disease. We might indeed have felt the tumor, but could not have told about its malignant or nonmalignant character. In another case belonging to this category we could not have had any ideas of the nature of the disease by tapping. By laparotomy we were able to see plain indications for removal of the tumor, and were consequently able to cure the patient.

Prof. Gusserow in this article expresses, we think, the views of most of those of us who have had much experience in abdominal surgery. With our present technique, even were the advantages to be gained by such a procedure far less than they really are, we need not hesitate to open the abdomen instead of making a puncture. When the general practitioner meets with a case of ascites where all implication of the circulatory apparatus, the liver and kidney have once for all been definitely excluded, it would certainly be well for him to call in the specialist before adopting the "puncture" method. Our own experience fully bears out the futility of attempting to arrive at a certain diagnosis in every case by examination (chemical and microscopical) of the fluid which has been aspirated; the only certain way is to use the

hand or the eye, or if possible both. Again we have seen more than one case which has come to autopsy where the patient had died after numerous aspirations and where the condition of things had led us to believe that a timely operation might have at least much prolonged the patient's life, even if the disease could not have been thoroughly eradicated. In these cases it seemed that valuable opportunities had been lost, and since an abdominal section not only gives the patient the best chance for complete recovery, but when employed as a palliative measure is more efficient than frequent tapping, it is in almost every case the better method. With respect to the "Peritonitis nodosa" of which Gusserow speaks, it does not seem clear to us that these were not instances of peritoneal tuberculosis, and if this were the case the success which attended the operations and which we have seen confirmed in our work would only go still further in proving his proposition.

Finally in these days when in both medicine and surgery we are all striving as much as possible to avoid working in the dark, and we wish to treat our patients for the disease they really have and not for a hundred and one others which they might possibly be suffering from, the advantages of an absolute diagnosis can hardly be overrated.

Dr. J. Whitridge Williams: I think we should take the case of Dr. Ashby's as a test to teach us to examine carefully for pelvic growth in all cases of ascites where heart and liver trouble are excluded. If we find ascites associated with a pelvic tumor the rational treatment is laporatomy and removal of the growth. The operation is very little more dangerous than punture and is more satisfactory. Ascites is often due to tubercular peritonitis papillomatous growths on the surface of the ovary, and solid tumors of the ovaries and tubes, both malignant and benign.

Dr. B. B. Browne: These cases recall a case, which I saw about three years ago, of large accumulation of ascitic fluid in which it was quite impossible to make out any pelvic tumor. Kidney and heart disease were excluded, and the conclusion was come to that the ascitis must be due to some intra-abdominal growth. An abdominal section was made, and after the evacuation of several gallons of ascitic fluid a papilloma of the ovary was found and removed. I saw the patient about three months ago, she was perfectly well.

Dr. Thos. Opie: I had a case of dropsy associated with large uterine fibroids. I made an abdominal incision with the intention of removing the fibroids, but finding that impracticable, the abdominal cavity was thoroughly sponged out and the wound closed. The patient was very much improved.

In many cases the simple opening of the abdominal cavity seems to at least temporarily relieve the patient, but the field is so new that we cannot assert positively just what permanent good can be attained by these operations.

Dr. Wm. E. Mosely: Dr. Ashby's case recalls one which I reported fully some time ago. The patient had ascites and I aspirated her twice. Both times the abdomen rapidly refilled with fluid. I then opened her abdomen and removed two papillomatous growths. Three years have now elapsed since the operation; there has been no return of the ascites although the growth has returned.

Dr. B. B. Browne: The question which is brought out most prominently is the propriety and advisability of an exploratory incision in those cases of ascites in which (heart, liver and kidney diseases having been excluded) no intrapelvic tumor can be felt. Of course where the tumor is large enough to be mapped out, the accumulation of ascitic fluid no longer obscures the diagnosis or interferes with any operation procedure which would be called for were no fluid present.

William S. Gardner,
613 Park Ave. *Secretary.*

The Keeley Institute at 42 Curtis St., has closed its doors from lack of patients and its furniture is advertised for sale.

Medical Proverbs.—Tender surgeons make foul wounds. Of the malady a man fears, he dies. Diseases are a tax upon our pleasures. He that would be healthy must wear his winter clothes in summer. He that sits with his back to a draft sits with his face to a coffin. A good surgeon must have an eagle's eye, a lion's heart, and a lady's hand. A physician is a man who pours drugs, of which he knows little, into a body of which he knows less.—*Practice.*

Cinnamon as an Antiseptic.—"No living germ of disease can resist the antiseptic power of essence of cinnamon for more than a few hours," is the conclusion announced by M. Chamberland as the result of prolonged research and experiment in M. Pasteur's laboratory. It is said to destroy microbes as effectively, if not as rapidly, as corrosive sublimate. Even the scent of it is fatal to microbes, and M. Chamberland says a decoction of cinnamon should be taken freely by persons living in places affected by typhoid or cholera.

In making a post-mortem examination of the remains of a female lunatic who died lately in the Kew Asylum, the doctors had an extraordinary experience. They found in the woman's internal organs three German silver teaspoons, which had been missing for a month prior to her death, as well as a piece of iron used to connect the handles of a door lock, and two triangular pieces of glass. It also transpired that three days previously another surgeon had abstracted a flat piece of steel five inches long and nearly an inch wide from the throat of the deceased. Yet none of these strange articles of diet had anything to do with her death, which was caused by disease of the brain.

"Gentlemen, you do not use your faculties of observation," said an old professor, addressing his class (*Brit. and Col. Drug*). Here he pushed forward a gallipot containing a chemical of exceedingly offensive smell. "When I was a student," he continued, "I used my sense of taste," and with that he dipped his finger in the gallipot and then put his finger in his mouth. "Taste it, gentlemen, taste it," said the professor, "and exercise your perceptive faculties." The gallipot was pushed toward the reluctant class one by one. The students resolutely dipped their fingers into the concoction, and with many a wry face sucked the abomination from their fingers. "Gentlemen, gentlemen," said the professor, "I must repeat that you do not use your faculties of observation, for had you looked more closely at what I was doing you would have seen that the finger which I put in my mouth was not the finger I dipped into the gallipot."

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Dr. Yount.

Dr. Yount commenced studying medicine in 1872 with Dr. G. C. Smythe, of Greencastle, Indiana, while he was pursuing his collegiate course in Asbury University, now De Pauw. In June 1874 he took his collegiate degree and in the following fall he entered Bellevue Hospital Medical College, New York City, from which institution he graduated in Feb. 1876. In April 1876 he opened an office in Lafayette, Indiana, and entered into active practice. The doctor soon took a front rank in his profession in Lafayette. He was one of the founders of the Tippecanoe County Medical Society. In 1890 he was elected Vice President of the Indiana State Medical Association. At intervals during his practice at Lafayette, he visited the leading hospitals and sanitariums in the East to study. He was a private pupil at different times under Drs. Paul F. Mundé, Francke H. Bosworth and the late George M. Beard.

Dr. Yount.

In 1891, Dr. Yount visited Europe devoting most of his time to the study of nervous and mental diseases in Salpetriere Hospital in Paris, under the eminent Prof. Charcot and Drs. Guinon and Parinaud. The Doctor also visited the great sanitariums in Munich, Dresden, Berlin and Vienna and made careful investigations into the most modern and successful methods of treating chronic nervous and mental diseases in all their various phases, stages and forms.

In January, 1892, Dr. Yount moved from Lafayette to the city of Chicago, where he is now located. At present he is Professor of Nervous Diseases in Post Graduate Medical School; Professor of Nervous and Mental Diseases Clinical College of Medicine and Specialty Hospital; Neurologist to Columbia Charity Dispensary, Neurologist to Chicago Charity Hospital; Neurologist to Haseltine Sanitarium.

The Medical Profession and the Politicians.

The medical profession of Colorado is interested in a battle now going on in the legislature of that State between the "Keeley Gold Cure" people and one of the imitators of that treatment. Two bills have been introduced, having for their object the establishing of a State hospital for the cure of inebriety. One bill provides for the Keeley treatment, the other for the imitation. It is probable that one of them will be passed.

The readiness with which all legislation inimical to the regular profession can be secured is due to the indifference of doctors to politics. Possibly no body of equal numerical strength could bring more weight to bear in a close campaign than could the medical profession. Politicians work for the interests of the men who control votes. Just as long as doctors wrap themselves in their dignity and refuse to take part in politics they will be walked upon and their interests disregarded by the law makers. If every assault on the interests of the profession were followed by a combined attack of the physicians on the political life of the man who makes it, politicians would come to us and say, "ask and it shall be given."

The remedy lies in the hands of the physicians. Resolutions passed by societies will do no good, but enthusiastic work against candidates will bring the consideration born of the fear of defeat, which is the ruling force in a politician's life. Eleven English cities have elected physicians as mayors in the past year. In Continental Europe every legislative body contains a large percentage of doctors. Are American physicians of so different a stamp that they cannot follow where their European brother leads? If Virchow can take an active interest in politics and hold an elective office, surely it is not beneath the dignity of an American M. D. to interest himself in the cause of good government and to labor earnestly in its behalf. The "political doctor" is in bad odor, and deservedly so, but a gentleman need not cease to be a gentleman because he desires and works for the defeat of some candidate unworthy of the trust to which he aspires.

The medical profession deserves no sympathy and it gets none except among its members. With the power to crush its detractors in its hands it prefers to lie down and allow itself to be kicked by any ward

politician who gets in the city council or the legislature. Heroic treatment of the politician at the polls is the cure. When will it be used?

ABSTRACTS.

Medicine.

WHITE STOOL.—The fact of persistent white stools being passed when the patient is on a mixed diet, raises the question whether colorless motions necessarily imply absence of bile. Dr. Walker has shown that when the pancreatic duct is obstructed, white stools result, and argues therefrom that the pancreatic secretion is a necessary ingredient of the coloring matter of the fæces. In the only necropsy of a case of psilosis which has been reported, the liver, pancreas and their ducts were all normal (*London Lancet*). Dr. Wynter Blyth made an analysis of the stools of a patient of Dr. Thin, and showed that more than half of the organic solids consisted of natural fats, apparently milk-fat, which had passed without being digested or saponified. Nearly six per cent of bile acids were present as soap, thus showing that bile was not altogether wanting. As the fat in the stool was only a fraction of the quantity taken in the milk, it followed that a considerable portion of the milk-fat had been digested, thus affording clinical evidence of the presence of the pancreatic secretion. In fact, milk is the only diet many of the patients affected with this disease can take. The practical importance of these observations is obvious. It has generally been held that colorless stools denote serious interference with the functions of the liver or pancreas, either due to disease of the organs themselves or to obstruction of their ducts. We see, however, from the observation which we have just considered, that such is not necessarily the case; and it is a question well worthy of serious consideration, whether in numerous other cases we are right in concluding that the liver and pancreas are not acting normally, because this symptom (colorless stools) is present. Dr. Thin suggests that the coloring matter of the fæces in psilosis is destroyed low down in the intestinal canal by bacterial action, and until some other agency has been discovered, or this theory shown to be untenable, we must conclude that the views hitherto held as regards the white stools, although probably correct in the majority of cases, are not complete, and further information is necessary before the matter can be considered to be satisfactorially settled.—*Med. Recoed.*

TREATMENT OF PNEUMONIA.—Dr. H. A. Hare (*Medical World*) bases the treatment of pneumonia upon a recognition of the general condition of the patient rather than upon the cause of his illness. If the patient has been strong and healthy until attacked and is seen within a short time after the initial chill and the consequent rise in bodily temperature, it will be found that his pulse is full and bounding, the cheeks flushed and the respiration somewhat rapid. At this time, and at no other, is aconite, veratrum viride, or antimony indicated, and they should be given fearlessly while they are given. From two to three drops of the tincture of veratrum viride or a similar quantity of aconite, preferably the former, are given every half hour until the decrease in pulse rate and pulse force and the appearance of a slight perspiration indicate that the full influence of the drug has been exerted. If veratrum viride has been given early enough it is certainly competent to abort an acute croupous pneumonia occurring in a previously healthy individual. If it is not given early enough the result of its administration will be to hurt the patient.

If there is marked dullness on percussion, with blowing breathing and the typical, fine crepitant râle of pneumonia, the use of these cardiac sedatives is contraindicated in most cases, because the disease has become thoroughly instituted and the stage is past when the remedy can do good.

Where there is tendency to cardiac failure and the apex beat of the heart seems at all muffled or feeble, digitalis is indicated. The best results from its administration will follow its use in the dose of not less than ten minims every eight hours rather than smaller doses frequently repeated. Particularly is digitalis indicated if the pulse seem feeble.

Where the skin has a tendency to be moist and the pulse, although large in volume, from the action of digitalis, seems to be surrounded by a relaxed arterial wall, the tincture of belladonna in the dose of five drops every four hours during the night and day will produce a wonderful change for the better. In some instances where there is considerable dyspnœa, it is well to administer no less than $\frac{1}{40}$ and frequently $\frac{1}{30}$ of a grain of strychnine every four to eight hours with the digitalis, and if the cough persists in the face of the belladonna, $\frac{1}{12}$ to $\frac{1}{8}$ of a grain of morphine may be given hypodermically.

When the crisis takes place in pneumonia we should always be on the lookout for collapse and cardiac failure and for the treatment of this accident no remedies are equal to full doses of strychnine and atropine.

In the asthenic cases of pneumonia the use of digitalis, belladonna and strychnine must be resorted to almost from the very first. Wet cups or leeches do much good in the early stages of acute sthenic pneumonia, but dry cups should be employed in the early stages of asthenic pneumonia.—*Polyclinic.*

Surgery.

CARBOLIC ACID AS AN ANTISEPTIC.—The swing of the pendulum is bringing antiseptic surgeons back to the point from which they set out. With the knowledge that wound complications were almost invariably dependent upon contamination by living matter, efforts were directed to the finding of a body capable of preventing such contamination without at the same time causing injury. Of all the antiseptics proposed or used, carbolic acid and mercuric chloride are the two that have shown themselves most deserving of confidence, and the second has been much more largely used than the first. Recent developments have, however, tended to demonstrate that mercuric chloride is not the perfect antiseptic that it has measurably enjoyed the distinction of being, and now comes the interesting announcement that Sir Joseph Lister (*British Medical Journal*, No. 1674, p. 163) has practically repudiated mercurial solutions for antiseptic purposes in surgical procedures, and has returned to the use of carbolic acid, which, in the strength (1:20) in which it is ordinarily employed, he shows to be germicidal to most of the noxious organisms.—*Medical News.*

A Case of Successful Laparotomy for Gunshot Wound of Intestine.—About February 10, 1891, Frank I., colored, 12 years old, received a wound from a thirty-eight caliber Smith and Wesson pistol, the ball entering about two inches below the umbilicus and to the left of the median line, penetrating the cavity, passing through the descending colon, and lodging in the left iliac bone. On the second day after the accident fecal matter passing through the opening made by the bullet established the fact positively that the colon had been wounded, and operation was decided upon. An incision was made through the walls of the abdomen, following the course of the bullet, about four inches in length. On reaching the colon it was found to be perforated on both sides, the openings being sufficiently large to admit the forefinger. Both were firmly stitched with continuous suture of silk, the cavity thoroughly syringed out with bichloride solution, and the wound closed and dressed with bichloride and iodoform dressing.

Notwithstanding the most unfavorable surroundings, a dirty, ill-ventilated, dark cabin, and with such nursing as negroes usually receive, the boy made a good recovery, and is now enjoying good health.—*Marshall in Wash. Jour. of Med. Surgery.*

The Treatment of Recurring Dislocations of the Shoulder Joint.—Richard (*Le Semaine Medical*), says the present method of treating recurrent dislocations of the shoulder joint are defective. Both resection of a part of the capsule and of the head of the bone give fairly good results, but they do not allow complete restoration of the movements of the joint. In order to obviate this defect he has devised the following operation: The deltoid muscle is separated from the clavicular and acromial attachments by incision and turned backward as a thick flap, and an assistant retracts the coraco-brachialis muscle; by this means the attachment of the subscapularis to the humerus and the front of the capsule of the joint is laid bare. The upper and lower borders of this muscle are then forced from their attachments to the capsule. The arm being rotated inward, the operator now passes three strong silk sutures through the thickness of the capsule in front of the joint above and below; they are passed through the substance of the subscapularis muscle. The sutures are passed in a vertical direction, and placed about two centimeters from one another. The ends of the sutures are tied, and by this means the anterior wall of the capsule is made thick and rigid. The cut surfaces of the deltoid are approximated with sutures, and the superficial parts then sewed up. The nerve supply of the deltoid is not involved in the operation, hence no paralysis follows. The author has performed the operation twice, and in each case with good results.—*Univ. Med. Maga.*

The Treatment of Gonorrhœa with Ichthyol.—Jadassohn (*Deutsche Medicinische Wochenschrift*) gives the results of his treatment of 106 cases of gonorrhœa with ichthyol. They were of both sexes. In the male cases examinations were made twice a week to determine the presence of the gonococcus, the secretion examined being obtained from the deep portion of the urethra. In the female cases the cervix uteri and urethra were both examined. The ichthyol was used in a one to five per cent solution in the anterior portion of the urethra, and one to ten per cent in the posterior portion of the male urethra and the cervical canal in females. A one per cent solution produces a burning sensation in the anterior urethra, but tolerance is soon established. A one per cent solution has a marked anti-gonorrhœal action, the gonococci disappearing rapidly. In a certain number of the cases there was a return of the trouble, but the ichthyol rapidly changes the secretion from a purulent to a watery one. The use of ichthyol is strongly recommended as one of the best means of treating gonorrhœa.—*Univ. Med. Maga.*

The Point of Election for the Injection of Iodoform in Tuberculous Hip Disease.—Bünger, in the *Centralblatt für Chirurgie*, December 24, 1892, describes his method of using iodoform in tuberculous disease of the hip. He says: "It can no longer be contested that iodoform has a distinct antitubercular action, not only in cold abscesses but also in tuberculosis of the joints. Instead of following the method of Krause and making the puncture for the injection above the greater trochanter, he advises the method of Küster. The spot where the femoral artery passes over the brim of the pelvis is determined, and a line drawn from it to the apex of the greater trochanter; where this line crosses the sartorius muscle at its inner border is the point where the trochar is to be introduced. The joint at this point is not only comparatively superficial, but the capsule also is thin, and there is an overlaying bursa, which, once in ten times, communicates with the joint cavity. A comparative test of the two methods of Krause and Küster on dead bodies gave for the former nineteen successes and six failures, for the latter twenty-five successes, the fluid being well distributed in the joint, and comparatively little around the outside. A Pravaz syringe of ten grams capacity, with a needle five to seven centimeters long, was used, five to ten grams of a twenty per cent mixture with glycerine being injected and repeated in from one to four weeks.—*Univ. Med. Maga.*

Gunshot Wound of the Bladder.—Dr. A. K. Worthington, *Denver Medical Times*, reports the following:

Case. C. P., æt. 32 years. March 22, 1891, while examining a revolver of European make, with a caliber approximating 29, he dropped it on the floor, and it was discharged. The bullet struck him on the anterior and inner face of the left thigh, an inch and a half below Poupart's ligament, passing upward, inward and backward. The external wound was trivial and the physician who was called applied a simple antiseptic dressing and did not return to see the case. He wisely did not probe for the bullet. Shortly afterward the patient rose to his feet and attempted to urinate, but could not do so while erect. Upon laying down on his side, he felt something roll around inside the bladder, and was then able to urinate while in the reclining posture. This condition existed for five days, urine always being passed while reclining, without special inconvenience. At the end of this time a slight cystitis began to make itself evident, and Dr. Pedersen was called in. He at once recognized the nature of the case, and asked me to take charge of it. Examination with the sound revealed the presence of the bullet, and after consultation with Dr. Munn, I determined to remove it by perineal incision. This was done on the next morning, March

28, the median incision being employed. Recovery was rapid, aseptic and uneventful, and there was no subsequent cystitis.

The location of the wound of entrance, in the groin, and the final lodging place of the bullet, in the bladder, give to this case a character that is unique and almost unprecedented. The bullet must have passed into the pelvis through the obturator foramen, fortunately avoiding the vessels there. It must have entered the bladder extra-peritoneally and at an oblique angle, so that a valve-like flap closed the internal opening and assisted in preventing the escape of urine. The bladder wound must have been rather high up on the side of the viscus, or infiltration would certainly have occurred.

Fractures of the Skull and Symptoms of Insanity.—Dr. Biggs presented at the January meeting of the New York Pathological Society a specimen from an autopsy made a few days before, on a man who had been committed to the Bloomingdale Asylum as insane. Thirteen days before death the man was found wandering around the streets, and unable to give an account of himself. No history could be obtained. There were no signs of injury. He was taken to one of the hospitals of the city, and, as he had been drinking heavily, his condition was supposed to be largely due to alcoholism. He was in the hospital several days, during which time he imagined himself back at his work, and tried constantly to get out of bed. He was then transferred to Bellevue Hospital, and there pronounced insane. His friends had him transferred from the Insane Pavilion to Bloomingdale Asylum, where he died rather suddenly. No positive diagnosis had been made, but the case was supposed to be one of general paresis. One of the orderlies stated that he had noticed that the man moved his right arm and both legs without difficulty but did not move the left arm. The autopsy showed a fracture of the skull, beginning about one inch above the external auditory meatus on the right side, and running downward and forward. There was a large extra-dural clot, three and one-half inches in diameter, and one inch thick; there was no fluid blood. The clot produced lateral compression of the temporo-sphenoidal lobe on the right side; the leg center was not involved. The only other changes found in the organs were those due to alcoholism. The case was of interest on account of the error in diagnosis, and the length of time elapsing between the receipt of the injury and death.—*N. Y. Med. Record.*

Epithelioma of the Upper Lip in a Boy.—Gangolphe (*Lyon Med.*) reports the following case: A boy, aged 15, came under observation on September 4th, 1891, with an ulcer of the upper lip. There was no sign or history, personal or hereditary, of scrofula or syphilis. The disease had begun eight months before in a tiny ulcer on the middle part of the upper lip, which, according to the patient, had followed a wound inflicted by the claw of a cat. A scab formed, which the patient used to pull off, and the ulcer gradually spread and became deeper. The base was rugged, and blackish in color, the edge raised and extremely hard. There was no discoverable glandular enlargement. The ulcer was freely excised, and the microscopic examination left no doubt as to the epitheliomatous nature of the lesion. At the date of report—more than a year after the operation—there was no sign of recurrence.—*St. L. Med. and Surg. Journal.*

Shortening After Femur Fracture.—At a late meeting of the London Medical Society (*Med. Week*) Mr. C. B. Keetley announced a method of fixing the bony fragments in fracture of the femur by means of steel pins, which he thought might enable union to take place without the subsequent shortening that so frequently results. He uses two thickly plated steel pins, about nine centimeters long, and bent at one end in the shape of the letter L. These are inserted into the respective fragments of bone passing through the whole thickness of the tissues, the way having been prepared by means of a bradawl, and the bent parts secured together in such a position as to maintain the fragments in fixed apposition. He insisted on the necessity of making the holes well in a vertical line with the limb. The irritation caused by the presence of these pins, which are not inserted until the tenth day after the accident, is extremely small. He had applied this method in two cases. In the first of these the pins had been withdrawn too soon (on the twenty fourth day) and angular union had resulted. In the second case (the patient was present) the result had been in every way satisfactory, but by an unfortunate accident the patient had fallen and fractured his thigh. The use of these pins did not in any way prohibit or interfere with the use of the ordinary apparatus for fixation. Jonathan Hutchinson had had from the long splint perfectly satisfactory results, and he saw no reason for resorting, at any rate in the usual run of cases, to this or any other alternative procedure. An anæsthetic was almost indispensable to the proper reduction of these fractures. Harrison Cripps thought that the procedure was only in exceptional cases necessary. He objected to an anæsthetic in order to facilitate reduction, and instanced a case in which the struggles of the patient while being anæsthetized had converted the injury into a compound fracture. He pointed out that the displacement was the result of spasm of the muscles of the thigh, and that if one waited until this had subsided, in the course of three or four days, reduction became comparatively easy. Openshaw said that if the limb were fixed under chloroform the result might be that the patient would be left in a painful position. It was much better to await the subsidence of the reflex muscular contraction before permanently fixing the limb. Dr. Keetley had exaggerated the tendency to shortening after this injury. In his hands the use of the long splint had proved extremely satisfactory. He looked upon shortening exceeding half or three-quarters of an inch as an indication of faulty application of the apparatus.—*Med. Standard.*

Kocher's Method of Reducing a Subglenoid Dislocation of the Shoulder Joint.—Bend the arm to a right angle and place the elbow against the side, then turn the hand and arm outward as far as they will go, and whilst in this position bring the arm forward until it reaches the median line. This will open wide the rent in the capsule. Now force the hand back on the *opposite* shoulder, in which manner it will almost invariably slip in place and generally this result occurs before the final motion is made.

By this method the shoulder can usually be reduced without anæsthesia and without great pain to the patient.—*Atlanta Medical and Surgical Journal.*

Therapeutics.

THE VALUE OF OPIUM IN MELANCHOLIC STATES.—At the meeting of November 27, 1890, of the Netherland Psychiatric Society at the Asylum in Utrecht, Holland, the value of opium in melancholic states was discussed. Dr. Winkler sets forth two conditions in which opium is of value. 1. In anxious states; indeed, the writer has often succeeded in aborting these conditions by means of large doses of opium. 2. In alternating psychoses with insomnia; here small doses act best. Dr. Van Parsijn would not be without the remedy. He has seen several cases of melancholia where the remedy gave good and lasting results; these were chiefly recent cases where the action was striking. He never uses morphine in such cases, but prefers opium. Dr. Doedes Breuning finds that the use of opium in the Dutch asylums is greatly decreasing. Dr. Van der Sith would limit the use of opium to acute cases. He quotes Schroeder van der Kolk, who used it only in pure melancholia.—*Psychiatrische Bladen. Med. and Surg. Reporter.*

PRESCRIPTION FOR EARACHE.—The following prescription will be found useful in alleviating pain in subacute inflammations of the middle ear, in the late stages of acute inflammation, in subacute inflammatory affections of the tympanic membrane, and generally in earache where there are no definite indications for operative interference. It may be used whether there is or is not discharge from the ear. Certain observations have made Dr. John Dunn, Chief of Clinic of the Richmond Eye, Ear, and Throat Infirmary (who furnishes this note), believe it has a bacteriocidal value; it may be sprayed directly into the middle ear, where there is a hole in the drum head.

℞.—Menthol.....gr. xx.
Gum Camphor.....gr. xx.
Liq. Albolene.....℥j—Misce.
Sig.—Drop into the ear several times daily.

If pus be found, wash out the external ear before using.—*Verg. Med. Monthly.*

DIRECT APPLICATION OF MENTHOL TO THE STOMACH.—A. L. Benedict, in *International Medical Magazine*, speaks well of the effect of a menthol spray applied directly to the mucous membrane of the stomach in cases of atony or catarrh of that organ. The method of procedure is as follows: The patient should be directed to take no food within four hours of the application, and the last meal should be a light one. Lavage is carried out in the ordinary way, plain water or a weak alkaline solution of about the body temperature being used, and the washing being repeated until the fluid returns free from shreds of mucous. A one to five per cent oily solution of menthol should then be sprayed into the stomach through the tube; an ordinary nickel-tube perfume-atomizer serves the purpose perfectly well. The spray may be directed into the funnel, or the latter may be removed and the tip of the atomizer introduced into the tube. The vapor, like the fluid previously used, should have an alternate ingress and egress; by pinching the tube close around the tip of the atomizer the stomach may be fully distended, and it should then be allowed to contract upon its gaseous contents, when the vapor and even drops of water will be expelled with considerable force from the mouth of the tube. The patient almost always states that he perceives the taste of peppermint in his mouth. The vapor should be introduced into the stomach, and that organ allowed to contract upon it, six or seven times, so as to insure the remedy coming in contact with the whole internal surface of the viscus. Details of several cases in which this method was used with great advantage are given, and the author suggests that other medicinal agents, such as nitrate of silver, might be applied to the internal surface of the stomach in the same way in cases of gastric ulcer, etc.—*Med. Age.*

CEREBRINE IN THE TREATMENT OF NERVOUS DISORDERS.—Dr. William A. Hammond reports excellent results from the use of cerebrine in nervous prostration, neurasthenia, hysteria, general paresis, etc. He details the method of preparation (*N. Y. Med. Jour*) of this extract. He states that five minims of this extract, diluted at the time with a similar quantity of distilled water, constitutes a hypodermic dose.

The most notable effects on the human system of a single dose are as follows, though in very strong, robust and large persons a somewhat larger dose is required, never, however, exceeding ten minims:

1 The pulse is increased in the course of from five to ten minutes, or even less in some cases, by about twenty beats in a minute, and is rendered stronger and fuller. At the same time there is a feeling of distension in the head, the face slightly flushed, and occasionally there is a mild, frontal, vertical or occipital headache, or all combined, lasting, however, only a few minutes.

2. A feeling of exhilaration is experienced which endures for several hours. During this period the mind is more than usually active and more capable of effort. This condition is so well marked that if the dose be taken at about bedtime wakefulness is the result.

3. The quantity of urine excreted is increased, when other things are equal, by from eight to twelve ounces in the twenty-four hours.

4. The expulsive force of the bladder and the peristaltic action of the intestines are notably augmented—so much that in elderly persons in whom the bladder does not readily empty itself, without considerable abdominal effort, this action is no longer required, the bladder discharging itself fully and strongly, and any existing tendency to constipation disappears, and this to such an extent that fluid operations are often produced from the rapid emptying of the intestines.

5. A decided increase in the muscular strength and endurance is noticed at once. Thus I found in my own case that I could "put up" a dumb-bell weighing forty-five pounds, fifteen times with my right arm and thirteen times with the left arm, while after a single dose of the extract I could lift the weight forty-five times with my right arm and thirty-seven times with my left arm.

6. In some cases in elderly persons an increase in the power of vision is produced, and the presbyopic condition disappears for a time.

7. An increase in the appetite and digestive power. Thus a person suffering from anorexia and nervous dyspepsia is relieved from symptoms, temporarily at least, after a single dose hypodermically administered.

These effects are generally observed after one hypodermic injection, and they continue from varying periods, some of them continuing for several days. In order that they may be lasting, two doses a day

should be given every day, or every alternate day as may be neccessary, one in the morning and one in the afternoon, and kept up as long as the case under treatment seems to require. The most notable effects are seen in the general lessening of the phenomena accompanying advancing years. When some special disease is under treatment, the indications for a cessation of the injections will be sufficiently evident either by an amelioration or cure or a failure to produce these results.

To the substance obtained in the manner mentioned and held in solution he has given the name of cerebrine as the one, in view of its origin, most appropriate.—*St. L. Med. and Surg. Journal.*

Bromoform In Pertussis.—Dr. C. W. Earle (*Medical Standard*, Vol. VII.) some years ago reported good results from bromoform in pertussis. Dr. F. W. Burton-Fanning ("Practitioner") has found the drug of great value. He considers it "of specific power against the main symptom of pertussis—the paroxysmal cough—on which depended the chief dangers of the disease." The remedy is sufficiently specific in its action to be of the greatest use in diagnosis. In seventeen doubtful cases in which he gave it the success or failure demonstrated the nature of the disease as determined by further observation. He finds that chronic enlargement of the tonsils, which perhaps temporarily superadded inflammation, is the condition most commonly coufounded with pertussis. Children with this affection often have severe paroxysmal cough, followed by vomiting, and sometimes by an attempt at a whoop, but here bromoform is useless.—*Med. Standard.*

Guaiacol Carbonate in Phthisis.—Guaiacol carbonate is a simple, chemically pure substance, free from odor, insoluble in water, neutral in reaction, and destitute of irritant effect on mucous membrane. It is not troublesome to the digestive organs, not being split up into its constituents, guaiacol and carbonic acid, until it has possed through the stomach. In the stomachs of phthisical patients, where generally there is an abnormally large quantity of saprophytic and parasitic bacteria, the compound is split up and a large amount of guaiacol set free by the fermentative processes. This arrests the development of the bacteria, and finally entirely frees the stomach from its unwelcome guests. The guaiacol set free is at once absorbed, so that even when large quantities of guaiacol carbonate are given there is no accumulation of guaiacol in the intestine. The use of the salt results in an improvement of the appetite followed by increased nutrition and body-weight, as well as by an augmentation of the general resistance of the organism to diseases. At the same time the anti-fermentative action of the guaiacol carbonate prevented the formation of gases in the intestines. Gradually the attacks of coughing lessened in violence and frequency, and the expectoration become loose and less abundant, assuming a more muco-purulent character. The fever was not directly influenced, and gradually entirely disappeared; the same was true of the night-sweats. The objective condition of the lungs corresponded to the improvement in the subjective feeling. Rales lessened and sometimes disappeared altogether; slight dullness often cleared up with surprising rapidity; in certain favorable cases large cavities steadily decreased in size within a few months, until finally they could no longer be detected. Frequent examination of the sputa often showed that the number of bacilli had diminished.—*Med. Standard.*

Influence Exerted by the Size of the Dose in Changing Therapeutic Action.—It was barely mentioned in text-books, and consequently was soon forgotten by the reader at the remotest period in the history of medicine—it had been known that certain remedies produced entirely different results when administered in small doses. This fact had been made by a certain sect the basis of a false train of reasoning, which, carried to its legitimate end, would lead to the conclusion that it was more potential to give none of a given medicine whatever. Among the medicines mentioned as acting differently, according to the size of the dose, were calomel, ipecac, antimony, sweet spirits of nitre, tincture of lobelia, rhubarb, chloride of sodium, digitalis, etc. According to the remedy and the size of the dose, we had here agents which might produce a sedative action on some portion of the alimentary tract, or cause vomiting or purgation, which might produce catharsis or diuresis; act as anthelmintic, or emetic; hasten or diminish cardiac action, etc. Again, it was necessary not only to consider the amount of the remedy in order to produce a certain effect, but also the modifying influence of climate from which the drug was obtained, the season of the year when gathered, and the part to be employed, whether roots, leaves, or flowers, and also the patient's peculiarities of constitution. There were medicinal plants which possessed similarity of structure, yet produced opposite physiological or remedial effects; while others, which seemed to have no similarity of appearance, produced like effects.—*N. Y. Medical Record.*

The Salicylates in the Treatment of Pleurisy with Effusion.—Dr. G. Dock, *Therapeutic Gazette*, draws the following conclusions:

1. Salicylic acid and its salts are among the most effectual agents in the treatment of pleurisy with effusion.
2. In effective doses the remedy is harmless, and, with proper selection of the preparation, and care in administration, causes little or no discomfort to the patient.
3. Salicylates act most promptly in pleurisies with serious effusion ef recent origin or of long standing, but they are efficient in simple dry pleurisy, and often act favorably in secondary pleurisy.
4. There is no evidence that they are useful in suppurative cases.
5. The drug acts a diuretic, but may have an effect on the pathological process, or on the cause of the disease.
6. Salicylates have a more marked action in pleurisy than have the diuretics, commonly so called.
7. "The duration of the treatment with salicylic preparations is less than with diuretics, common salt, or roborant medications." (Engster.)
8. The remedy can be used at the earliest period, and favorably affects all symptoms.
9. The drug may be given in the form of the acid, or any of its salts, in doses of a drachm of the former, or 1 or 2 drachms of a salt daily. In ordinary cases it is not necessary to give the large doses, and 60 to 90 grains of sodium salicylate or salol daily may be

considered full beginning doses, to be diminished one third or one half after the effect is manifested.

10. The ordinary precautions must be observed in giving the drugs, and during their administration the total amount of urine should be measured daily.

CHLORATE OF POTASH AS A GALACTAGOGUE.—Dr. A. Harkin (*Wiener Med Presse*, No. 6, 1893), speaks highly of the chlorate of potash as an active galactagogue which is not injurious either to the mother or child. He has used it for over fifty years as a means of increasing the flow of milk in nursing women. He prescribes the drug as follows:

℞ Chlorate of potash.....gms. 28, ʒvij.
Distilled water.....gms. 560 ℥xviij.
Two tablespoonfuls three times a day before meals.

Already in the beginning of the treatment, within twenty-four hours, the patient often observes the breasts increase in size; soon an increase in the secretion of milk sets in, with consequent better nourishment of the infant. Not only in nursing women, but also in animals has this property of the drug been proven. In cows and goats, by experiments made at several dairies, it was found that the milk secretion was increased even up to forty per cent. This action continued for four days after the drug was discontinued. It does not lower the general condition, but rather increases it. In one cow, which had lost its milk from an attack of puerperal fever, it reduced the temperature rapidly, and restored the lacteal flow. If the milk be already secreted abundantly it has no effect. Given immediately after labor it produces an immediate add copious secretion.—*Lancet Clinic.*

THE ACTION OF COCA.—The *Trained Nurse* reprints from the London *Hospital* an article in which the writer, who states that he has had considerable experience with Mariani's coca wine, concludes as follows:

"The scientific study of cocaine has led to a better comprehension of the mysterious qualities of the coca leaf. The first effect is sedative, rapidly followed by stimulation, in which the heart beats are quickened, the nervous system becomes more active, the intelligence more acute, and the muscles pass more easily into a state of contraction. Dr. Mantagazza says that when he was under the influence of coca he had an irresistible inclination to gymnastic exercise. The absence of the sense of hunger seems to be due not only to the anæsthetic effect of cocaine on the nerve ends of the stomach, but also to the fact that coca is an actual economizer of food, and so modifies the vital processes in muscle as to affect its chemical activity and render it capable of performing an equal and greater amount of work with a lesser consumption of carbohydrates (Stockman). The absence of emaciation or subsequent debility or other bad results after the most exalted powers of the organism have been called forth points to coca being more than a nerve stimulant, but also an actual economizer of the bodily expenditure. If it diminishes the consumption of carbohydrates during muscular activity—that is to say, enables the machine to work with less fuel—less oxygen will be required, and hence is explained the effect coca has in preventing breathlessness when ascending high mountains. Too much stress cannot be laid on the importance of using only a reliable preparation of the drug.—*N. Y. Med Jour.*

WARM SUBLIMATE SOLUTIONS.—Ahl (abstract *Archives d'Opthalmologie*) by means of a large number of bacteriological and chemical researches, has ascertained that the application of heat to solutions of sublimate increases their antiseptic power, while it diminishes their poisonous and corrosive effects. The following are his conclusions:

1. The antiseptic action of a solution is increased if it is heated to a temperature of 40° C.

2. A solution of 1 to 2,000, or even 1 to 1,000, heated to 40° C., may be used without danger for deep-seated lesions of the lungs, of the pleura, and of the peritoneum, the bactericidal effect corresponding to that of a cold solution of 1 to 500.

3. A solution heated to 40° C. stimulates the generative action of the tissues and accelerates the heal-process. On the other hand, a cold solution of 1 to 1,000 has less antiseptic action than a hot solution of 1 to 10,000, because the latter penetrates farther.

4. Weak and hot solutions of sublimate may be used with perfect security, so far as the caustic effects are concerned.—*Therapeutic Gazette.*

CHLORAL AND CAMPHOR IN THE TREATMENT OF CHANCHROID.—In the March number of the *Annales des maladies des organes genito-urinaries* there is a summary of an article by Dr. E. Cavazzani, published in the *Giornale italiano delle malettie veneree e della pelle*, on the treatment of soft chancre with a mixture of five parts of chloral hydrate, three of camphor, and twenty-five of glycerine. The author reports twenty-six cases treated with this application in which a cure was attained in from two to eighteen days. It is said that the secretion diminishes rapidly and soon ceases altogether, that the local inflammation subsides notably, that the epithelium is regenerated speedily, and that suppurating buboes are a rarity.

TREATMENT OF MENIERE'S DISEASE.—Dr. Roméo Gongardi (*Annales des Malad. de l'oreille*, December, 1892,) reports three cases of Ménière's disease cured by the administration daily of three powders containing each three grammes of bromide of potassium, and three pills (valerianate of iron one gramme, opium twenty-five centigrammes, extract and powder of cascara sagrada q. s. ad pil. xii). The cure was permanent. The superiority of this method over the cinchonism suggested by Charcot consists in:

1. The remarkable improvement of the hearing.
2. The disappearance of the vertigo after the first day's treatment.
3. The permanent disappearance of the titubation. —*Univ. Med. Maga.*

THE TREATMENT OF BOILS BY BORIC ACID.—*L'Union Medicale* quotes Alison as having obtained good results in the case of general furunculosis by the administration, for eight or ten days, of from 10 to 15 grains of boric acid a day, divided into two doses. At the same time, four or five times a day, the inflamed areas were washed with a hot solution of boric acid, in the strength of four per cent. Between the applications of this lotion compresses were applied to the diseased parts, which had been wet with the same solution of boric acid. In this way he claimed to have been able to relieve the boils which had already formed, and to do much toward preventing other outbreaks. By this means he thinks it possible to avoid surgical intervention.—*Therap. Gaz.*

Obstetrics.

Analysis of Twenty-five Cases of Hydatidiform Moles.—The author emphasizes the following points.

1. Primiparæ are not rarely affected; and the average age is younger than generally estimated.

2. There may be present any of the ordinary changes of breast, labia, etc., found in normal pregnancy.

3. There is medico-legal importance in the following: *a*, origin from impregnated ovum only; *b*, the placenta once formed is never the seat of this myxœdematous change; *c*, the mole may be carried beyond term or after a living child; *d*, the appearances after delivery of a mole may be indistinguishable from those after childbirth.

4. Reflex symptoms of nausea and vomiting common to pregnancy, so far from being absent or rare, are rather frequent, and as a rule, are early, severe, progressive.

5 There may be œdema without albuminuria. Schul, who has recently made a study of the relation of albuminuria to hydatidiform mole, finds that, while it does not occur oftener, it generally appears earlier than in normal pregnancy.

6. Uræmia may be a complication, and, with convulsions, is amenable to the same treatment as in pregnancy.

7. Too much stress has been laid on the so-called characteristic discharge of thin watery blood, with occasional cysts. For while in the cases cited the flow may not have been pure blood, it was so nearly that in a large proportion of cases that no distinction was noted. Therefore, any vaginal discharge, watery or bloody, slight or considerable in amount, intermittent or constant, and without cysts is perfectly consistent with hydatidiform mole.

8. Sudden hæmorrhage, sufficient to cause grave general symptoms, is frequent; as also exhausting intermittent flow.

When once the diagnosis is made the following suggestions are submitted as to treatment:

1. The patient is liable to repeated hæmorrhages sufficient to cause grave general disturbance, and to sudden severe hæmorrhage.

2. A closed rigid os is almost the rule even after severe hæmorrhage.

3. The mole can be delivered without complete dilatation, and with no more loss of blood than is almost certain to follow later, when it may not be easy to interfere.

4. The uterus contracts well after being emptied, even when pains have not been present before dilatation was begun.

5. Uterine stimulants and tampons will generally have to be supplemented by the hand or currette.

6. Tampons with delay increase the danger of infection.

7. Incomplete expulsion makes hæmorrhage and sepsis liable.

8. The possibility of a thin, uterine wall should be borne in mind when the curette, the hand *in utero*, or Crédé's method of expression are used.—*Boston Medical and Surgical Journal, Epitome.*

Post-Partum Hæmorrhage.—How to prevent this formidable complication of labor, and how to check it when once the flood-gates have burst open are problems of the greatest importance to every practitioner throughout the land. Although one reads a good deal of it in text-books on obstetrics, it is fortunately by no means common, at any rate in its severer forms. Many a practitioner with extensive experience of the lying-in room has never met with a fatal case, and the records of over 11,000 labors at one of the London hospitals show only one fatal instance of post-partum hæmorrhage. In cases of moderate severity almost any of the means usually resorted to will suffice to excite uterine contraction, and so put an end to a condition full of danger for the woman, and full of anxiety for the medical attendant. The question is really what can be done to goad into activity the typically inertia-stricken uterus. Shall we pack the uterine cavity full of gauze as a last resort, or shall we content ourselves with temporarily arresting the outpour by manual pressure? To pack the uterus tightly enough to exercise efficient pressure on its walls is a task which few would care to attempt, while the ever-present danger of introducing pathogenic organisms from without cannot be overlooked. We have a shrewd suspicion that the cases in which success has followed the more radical measures would have proved amenable to milder treatment if persevered in.—*Med. Press.*

Action of Hydrastis Canadensis on the Uterus in the Puerperal State.—Bordé (*Rif. Med.* February 25, 1892) gives the results of his experience with hydrastis and its preparations. As regards hydrochlorate of hydrastine, he finds that (1) it has no action on the physiological loss of blood during and immediately after labor; (2) it has no influence on the involution of the uterus during the puerperium; (3) it has very little influence on the lochia, its action, if any, being to cause (*a*) greater persistence of the red lochia, (*b*) delay in the expulsion of clots, (*c*) greater fætor of the lochia; (4) it does not assist the expulsion of clots and other bodies contained in the uterus. As regards the extract of hydrastine, he concludes from the observations on twenty-five normal labors in which the drug was given in large doses during and for ten days after delivery that, if this drug has any action at all on the uterus in the puerperal state, it is to diminish the activity of its reaction and contraction, and therefore to increase both the loss of blood and the subsequent troubles. Finally, he gives it as his experience with the drug, in a few cases of nonpuerperal uterine hæmorrhage, that it always failed.—*Brit. Med. Jour.*

Perforation of the Intestines in the Eighth Month of Gestation.—Lihotzky (*Centralblatt für Gynäkologie*), reports the case of a woman, age thirty-three, admitted to the hospital suffering from an acute peritonitis. Examination showed that she was in the eighth month of pregnancy; fœtal heart sounds could not be heard. The patient was in a moribund condition, and all active interference was contraindicated. She died on the following day. A subsequent post-mortem demonstrated these interesting facts. The uterus contained an eighth month fœtus in a condition of beginning maceration. The peritoneum presented the changes of a purulent peritonitis. The handle of a small spoon protruded from a perforation in the outer side of the duodenum descendens. Two years and a half ago the patient suffered from a mental derangement caused by an attack of influenza and domestic troubles. She then

attempted suicide by swallowing a spoon. At the hospital to which she was admitted no signs of a foreign body could be found, and as her mind was still deranged, her statements were discredited. The woman regained good health. The last pregnancy was perfectly normal. She had no pain, and her appetite and digestion were good until four days before her death, when she was suddenly seized with nausea and severe abdominal pain.—*American Journal of Obstetrics.*

SUDDEN DEATH IN CHILDBED.—Tarnier (*Jour. des Sages-Femmes*) describes a case in which all went well after labor till the patient stepped out of bed, saying: "To-morrow I shall leave the hospital." She at once felt faint, and died in two hours. A necropsy was made. Coagula, formed by normal thrombosis, were detected in the uterine sinuses. There was also embolism of the pulmonary artery, no doubt caused by the detachment of a clot in the uterus. Sudden death was first discussed scientifically by Lancisi and the obstetrician Dionis, about 1710. Charcot, in 1858, wrote a memoir on sudden death in childbed. Simpson was the first to show that endocarditis develops in some cases during the puerperium. In one case the intrapericardial part of the aorta ruptured. In Depaula's case a cyst in the interauricular septum gave way. Thrombosis or embolism is the most frequent cause of sudden death after labor. Phlebitis of the large veins of the leg is an obvious source of danger. Pulmonary apoplexy has been seen, but is less frequent. Armaingaud recently published two cases of angina pectoris in childbed; one died, the other was saved, he thought, by wet cupping; when the first saw her the arms were œdematous. Sudden death is relatively much more frequent in the puerperium than in any other condition, and embolism is the commonest cause, especially after flooding, for the fibrin increases in proportion toward the end of the pregnancy, so that an anæmic woman in childbed is very liable to the development of clots, especially as the circulation is enfeebled.—*St. Louis Med. and Surg. Jour.*

Diseases of Children.

DENTITION FEVER AND ITS TREATMENT.—Müller (*Correspondeż-Blatt*, October 15, 1892) says that posterity will look with wonder upon the difference of opinion now existing whether there is really a fever depending upon dentition alone. He believes, and bases his belief upon many observations, that certain cases of ephemeral fevers occur in children where the most scientific examination fails to show any lesion except eruptive teeth, and the fever rapidly disappears upon lancing the gums. He advises the following manner of performing gum lancing. An assistant fixes the shoulders and legs of the child, while a second fixes the head. The index finger of the left hand is pushed between the jaws, and the tongue pushed somewhat aside. Then with a scalpel laid flat on the tooth he cuts off the little cap surmounting the point of the tooth (this can be easily discovered by the paler character of the gum in this position), or he makes parallel or cross cuts over the top of the tooth, thus excising a small portion of the gum. If the scarification is done in this manner the point of the tooth will remain free, and a scar will not form over it. The mother is directed to wash the scarified surface several times daily with a soft cloth wet in carbolic acid solution, to prevent infection and prevent the healing of the cut. The amount of blood lost is insignificant. This little operation will always relieve the child when the diagnosis is correct. It is not to be done, however, unless the physician is certain that no other cause for the fever exists.—*American Med. Magazine.*

Toxicology.

ACONITE POISONING.—A woman, aged thirty, took at a dose, with suicidal intentions, four drachms of fluid extract of aconite. She immediately felt a burning sensation and pain in her stomach, followed by lost power of standing, and became very restless. I arrived about twenty minutes after the poison had been taken, and found her held up by friends over the *pot de chambre.* She had no control over her bowels, and was in agony from the fearful burning sensation in the stomach. After she had filled the pot for the second time, I ordered her undressed and laid on the bed, and administered emetics and atropine hypodermically. In spite of emetics, she could not vomit. Her skin was cold and clammy, with a feeling of numbness. With the aid of two assistants, I began rubbing her with brandy. She complained of swelling about the tongue and throat, and had convulsive twitchings of the muscles about the face and neck, also dimness of sight; pupils widely dilated. I gave her another hypodermic injection of atropine. Now the symptoms grew rapidly worse. She was unable to move, and almost lost consciousness. She had foaming at the mouth and could not swallow. Lockjaw, deafness, and complete loss of sight followed; the breathing was slow and regular; the pulse was imperceptible; the hands were clinched.

All this time the assistants were rubbing her with brandy, and in the mean time I sent for *eau sedative* (Raspail's) and tincture of belladonna, of which I gave her a dose, and ordered the sedative water to be used for rubbing in place of the brandy. She began to improve a little; her sight was restored to a certain extent, she was now able to hear, lockjaw had disappeared, and she began moving a little. But now she began having attacks of the most violent description; breathing became very difficult. She was complaining of pain in the heart and constriction of the chest. Her eyes were brilliant and sparkling and glared wildly, sometimes resting with a fixed stare. She felt a feeling of death, and appeared to suffocate. She was gasping for air and became very violent, and it was difficult, with the united force of three, to keep her in bed. The pain in the heart was fearful. She wanted to tear the breast of the left side, and it was a hard task to keep her from injuring herself. Asphyxia was all along expected, until all at once came a little improvement. She had repeated attacks of pain in the heart and suffocation. She wanted to be rubbed over the chest continuously, for she said it relieved her, and she was rubbed for over four hours constantly until her skin was sore, and I gave her several doses of belladonna. She was improving fast, but still had no power to move her hands and feet, the former being still clinched, and there was no sensation in the fingers. We began then rubbing her hands and feet, and in a few minutes she was again able to move them. Five hours after she had taken

the poison I left her feeling quite well, but greatly exhausted. She had not vomited a particle, but was well purged. Next morning she had vomitings, headaches and a slight fever, and still had slight numbness in the fingers, but on the following day she was up and around, feeling as well as ever.—*Alterlah in N. Y. Med. Journal.*

A Remarkable Case of Carbolic Acid Poisoning.—In the *Bulletins de la Société anatomique de Paris*, 1893, No. 2, there is a brief account, by M. Jayle, of the case of a girl, eleven years and a half old, who, having a little excoriation of the right index finger, wrapped the finger in a piece of cloth moistened with a few drops of a mixture of nine parts of carbolic acid and one part of glycerine. On the following day the finger was of a grayish hue, and subsequently it became black, but without pain. The finger was amputated at the metacarpo-phalangeal joint, and not only the soft parts, but also the phalanges were found to be black. The child's general health was good and an examination of the urine showed nothing abnormal. These facts, together with the small amount of the drug used, make the poisoning difficult of explanation.—*N. Y. Medical Journal.*

Gynæcology.

A New and Rapid Method of Removing the Uterus.—At a recent meeting of the Kansas City Academy of Medicine, Dr. Emory Lanphear presented a number of fibroid tumors, sarcomata, etc., removed by a new method of abdominal hysterectomy. The abdomen and vagina having been carefully sterilized, he makes an incision in the median line, terminating as close to the pubes as possible, draws the uterus with one tube and ovary to one side and applies a clamp to the broad ligament; a strong ligature is passed a half inch from this, including the blood vessels, and tied; the intervening tissue is then cut with scissors. Upon the opposite side the same procedure is carried out. When done, the uterus (hitherto held down by the broad ligament) can be lifted up into the wound and separation from bladder and rectum easily accomplished; these incisions, before and behind, are carried into the vagina, when a Kelly's or Polk's clamp is introduced through the vagina as close as possible to the uterus, its points reaching the ligature already tied in the broad ligament. As soon as properly applied it is closed, and its fellow clamp inserted upon the other side, when the uterus is quickly cut away with curved scissors. The pelvis is irrigated, and the abdominal wound closed and drainage made through the vagina as in cases of vaginal hysterectomy. The clamps are removed in forty-eight hours. The operation can be made in twenty-five to thirty minutes, being much easier than even a vaginal hysterectomy with clamps. By the rapidity allowed and by the good drainage secured Dr. Lanphear thinks this operation can be done almost as safely as an ovariotomy—certainly as safely as a vaginal hysterectomy; and it is much preferable to any method which leaves a pedicle or stump behind. He finds it is not necessary to unite the bladder to the rectum, as union takes place just as quickly without sutures as with them.—*Jour. A. M. A.*

Significance of Vaginal Discharges.—A leucorrhœa inodorous or of mild odor persisting during the climacteric, accompanied by increasing hæmorrhage, is suspicious, and demands investigation.

A leucorrhœa profuse, of peculiarly fetid odor, grumous, excoriating, appearing early or late during the climacteric, with profuse hæmorrhage, is reasonable evidence of cancer of the cervix.

A leucorrhœa moderate in amount, ill-smelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hæmorrhage, suggests cancer of the corpus uteri.

A leucorrhœa discharge with hæmorrhage containing material like the washings of meat, is said to indicate sarcoma.

A watery discharge, as a rule, occurring during menstruation, odorless or of little odor, persisting, accompanied by profuse hæmorrhage, indicates fibroids; with little or no hæmorrhage, polypi. Profuse bloody discharges coming on gradually with declining menstruation, ceasing usually with the menstrual flow, points to fibroids. Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring, as a rule, after the menopause, indicate cancer.

A gradually increasing amount of menstrual flow is suspicious and needs investigating. "Post-climacteric hæmorrhage in a fibroma of the uterus of long standing, form one of the principal grounds for the suspicion of sarcoma." (Börner.)

The early recognition of malignant disease and the possible prevention of that fatal exhaustion which accompanies it by the administration of drugs, and the application of those methods which, in a measure, may be supposed to offset the terrific drain on the nervous system, inasmuch as present experience shows that early removal of diseased tissues prolongs life, and the importance of early diagnosis and treatment can hardly be over-estimated.—*N. E. Med. Gazette.*

Dysmenorrhœa, Menorrhagia and Leucorrhœa.—Goodell (*Pratice*) recommends the performance of rapid dilatation of the uterine canal for dysmenorrhœa due to acute anteflexion and stenosis. If there has been menorrhagia, curetting is also done for the purpose of removing granulations from the endometrium. Always after curetting, the uterine cavity is irrigated with a 1:2000 bichloride of mercury solution through a double canula, and every loose particle washed away. A strip of iodoform gauze is then carried up to the fundus and packed into the canal, and a suppository of iodoform (grs. x-xx) placed in the vagina. Curetting and packing with iodoform gauze is also useful in cases of endometritis associated with copious leucorrhœa. Dr. Goodell has performed rapid dilatation about 400 times for dysmenorrhœa, in addition to the combination of this operation and curetting for other conditions, and has not yet seen any bad results from it. The presence of active inflammatory tubal or ovarian disease is a contraindication to the operation.—*Univ. Med. Magazine.*

Some Interesting Ovariotomies.—McMurtry (*Medical and Surgical Reporter*) reports three cases of ovariotomy, the peculiar features of which still further confirm the statement of Mr. Greig Smith, that this is "the most successful major operation in surgery."

Two of the patients were over seventy-one years of age.

Case I. traveled from Kansas City to Louisville in order to have the operation performed. After opening the peritoneal cavity, the operator found numerous intestinal and bladder adhesions, which were old and firm. There were two cysts present, and the one on the left side had a pedicle which was the largest that the author had ever dealt with. It was quilted with a double ligature and another ligature around. The patient made an easy and complete recovery.

Case II. had a double ovarian cyst, and when operated upon was in a serious condition—rapid pulse, high temperature and vomiting. Peritonitis was active around the larger cyst, and in addition to the old adhesions fresh ones were forming. It was found that the pedicle of the larger cyst was twice twisted, the circulation being shut off from the sac, and was sloughing. The interior of the sac was filled with clots and dark-colored fluid, the result of hæmorrhages in the interior from obstruction of the circulation by this twisted pedicle. Both tumors were removed, the peritoneal cavity was thoroughly irrigated and trained, and she made an unusual prompt recovery.

Case III. was but twenty-one years old, and had active peritonitis at the time of operation, from the sloughing sac of strangulated multilocular ovarian cyst. In separating the adhesions the sack ruptured and about a gallon of pus ran out over the table. Both tumers were removed, the cavity irrigated with three gallons of water and the patient put to bed very considerably shocked. She reacted well and finally recovered, but not until after she had passed through a typical attack of typhoid fever lasting five weeks.—*Univ. Med. Maga.*

Pathology.

HORSLEY ON PATHOLOGY.—In his introductory remarks delivered in the Section of Pathology at the Nottingham meeting of the British Medical Association, July, 1892, Horsley ventured the assertion that pathology, as such, is almost unknown among us. What is commonly spoken of as "pathology," taught as "pathology," and made the subject of examinations in pathology, is not pathology; it is morbid anatomy. The pathologist should be the student of disordered functions as well as of disarranged structure; morbid anatomy is, therefore, but one side of his work, pathology is the other. What is required at the present day is the accurate determination of the aberrations of normal function, and seeing what strides normal physiology as a science has made, no difficulty attends the pathologist in this new and fertile field. The diseases of the respiratory functions are taken as a concrete example. A mass of facts has been accumulated in elucidationof the various changes in the structure of the lungs produced by pneumonia, phthisis, etc.; but investigation of the degree and effect of the loss of the respiratory function, of the disorder of the normal oxygen and carbonic acid ratios is lacking. Yet this is what kills, this is the whole work of the disease, and this is what must be solved before the treatment of such disease can be worthy of mention other than as empirical palliation. Before this, the pathology of the diseases of the respiratory organs, the facts of morbid anatomy will seem more and more restricted as the intricacy and breadth of the problems it is often supposed to solve are properly considered and appreciated. This indifference to pathology is due to want of familiarity with modern progress in physiological and chemical research.—*British Med. Journal, Epitome.*

PUBLISHER'S DEPARTMENT.

Announcement from Department of Physiological Remedies of Parke, Davis & Co.

We learn with much interest that Messrs. Parke, Davis & Co., of Detroit, Mich., have undertaken the manufacture of some of the newer physiological remedies. They are now prepared to supply desiccated thyroids and cerebrin, and expect to extend this list materially. The following announcement is made by this enterprising firm:

* * *

As a result of the well-known investigations of Dr. Brown-Sequard and other eminent therapeutists, the materia medica has recently been largely extended by resorting to the use of products representative of certain glands or tissues of the animal economy. As we have always made the manufacture of digestive ferments a specialty, and enjoy every facility for the preparation of products of this character, we are undertaking to supply some of these newer remedies, of which we now have ready desiccated thyroids and cerebrin.

Desiccated thyroids are in the form of impalpable powder representing in permanent form the thyroid glands of sheep. This product is of such strength that 15 grains represent one gland of the average size. Desiccated thyroids are highly recommended in the treatment of myxœdema.

Cerebrin is prepared after the formula of Dr. William A. Hammond' and is put up in glass-stoppered ounce vials. While Dr. Hammond has his recommended maceration of the brains of six months, we have modified his method in such manner that we are enabled to thoroughly extract the crude material in as many days.

One serious drawback to the use of these products has been the difficulty in getting the necessary crude material, and the disagreeable character of the work involved in their preparation.

Again, it is only by the most scrupulous attention to the minutest details that asepsis in the finished article can be secured and assured.

The well-known reputation of our house is a guarantee of our ability and intention to fulfill every requisite. We do not doubt that many interesting results will follow the treatment of myxœdema by desiccated thyroids.

It is our purpose to extend this list from time to time. Descriptive literature of those announced will be supplied on application.

PARKE, DAVIS & Co.

PERLOIDS.—Messrs. H. Planten & Son, New York, has succeeded in making a pearl-shaped capsule to which they have given the name perloids and offer these to the medical profession as being superior to anything of this form on the market.

Perloids are prepared from the finest materials and filled with such valuable medicinals as apiol, copaiba, creosote, etc., etc. They are perfectly soluble, sym-

metrical of shape and elegant of finish, making them just the desideratum for prescribing.

Samples of Perloids, as well as Hard and Elastic Soft Capsules, will be sent on application.

Persistent Continued Fever: Treatment by Antipuralgos.

In several cases of persistent continued fever that would not yield to the ordinary antipyretics that have been so popular with the profession, I determined to try the new antipyretic—antipuralgos—and I am glad to say that in each case prompt and definite action from the remedy was obtained. My patients recovered rapidly and the remedy acted so charmingly that I was convinced that it possessed real merit and therapeutic properities. Recently I have tested its virtues in two more cases of continued fever, evidently of malarial origin, where other remedies of a similar character had failed, but where antipuralgos given in the same way acted admirably. All these cases were conducted to a favorable issue. The use of this remedy was attended by no depressing or unpleasant effects, but it invariably controlled the fever after a reasonable period had elapsed. During the last few days I have had occasion to use antipuralgos in a case of typhoid fever and I find that in that case also it reduced the temperature better than any remedy that I have ever tried. This case is also doing well under its administration and as it progresses I will carefully note effects and at some future time report results.

A. A. Abermathy, M. D.
Morristown, Ind.

Announcements.

Section of General Medicine of the Pan-American Medical Congress.—This unique assemblage promises to be one of the most important events that has occurred in the history of medicine in the Americas. Its success is assured by the large number of valuable papers already promised. The Section on General Medicine, which is one of the most important that has been created, bids fair to be one of the most successful in the entire congress; and already many valuable contributions are in process of preparation, and will be read at the meeting in September. It is hoped, with the hearty coöperation of all physicians living not only in North but also in South and Central America, that the work in this section will be memorable; and each physician living on this continent is requested to join this most important section, and to prepare a contribution to be read before that body. It is especially requested that those intending to join this Section or to read papers shall at once send their names, with titles of papers, to the secretary, Dr. Judson Daland, No. 319 South Eighteenth Street, Philadelphia, Pa., so that they may be noted on the calendar and given their appropriate places.

The Pan-American Medical Congress.

The Section on Dermatology and Syphilography has been fully organized as follows:

Honorary Presidents: Dr. Silva Aranjo, Rio de Janeiro, United States of Brazil; Dr. L. Duncan Bulkley, New York; Dr. John Forrest, (Spanish-Speaking), Charleston, S. C., Dr. Juan C. Castillo, Lima, Peru; Dr. Louis A. Duhring, Philadelphia; Dr. Le Grand N. Denslow, St. Paul; Dr. Maximiliano Golan, City of Mexico, Mexico; Dr. James Nevins Hyde, Chicago; Dr. Prince A. Morrow, New York; Dr. R. B. Morison, Baltimore; Dr. D. W. Montgomery, San Francisco; Dr. A. Ravogli, Cincinnati; Dr. A. R. Robinson, New York; Dr. Antonio Rubio, Pinar del Rio, Cuba; Dr. M. Lucas Sierra, Santiago, Chile; Dr. R. W. Taylor, New York; Dr. A. Van Harlinger, Philadelphia; Dr. J. C. White, Boston, Mass.; Dr. Edward Wigglesworth, Boston, Mass.

Executive President: Dr. A. H. Ohmann-Dumesnil, No. 5 South Broadway, St. Louis, Mo.

Secretaries: Dr. Wm. S. Gottheil (English-Speaking) 25 West Fifty-third Street, New York, N. Y.; Dr. Cárlos Lloveras [Piedad 944], Argentine Republic; Dr. Viscarra Heredia, Bolivia; Dr. W. S. Barnes, [Leper Hospital], British Guiana; Dr. Joan P. Gabiza, United States of Brazil; Dr. J. E. Graham, Canada; Dr. Enrique Robelin [Jesus Maria 91], Cuba; Dr. Daniel E. Coronado [Calle 13, núm 120], Republic of Columbia; Dr. Daniel Nuñez, Costa Rica; Dr. Angel Rivera Paz, Guatemala; Dr. H. G. McGrew, Hawaii; Dr. Strachan, Jamaica, W. I.; Dr. P. Numa Rat, Leeward Islands, W. I.; Dr. Francisco Bernaldez [Escuela de Medicina], Mexico; Dr. Bevan N. Rake, Trinidad, W. I.; Dr. Manuel Bonasso (Arapey Esquina Colonia), Uruguay; Dr. Adolfo Briceño Picón, Venezuela.

Advisory Council: Dr. T. B. Keher, St. Louis; Dr. E. B. Browson, New York; Dr. Jos. Zeisler, Chicago; Dr. J. P. Knoche, Kansas City, Mo.; Dr. W. T. Corlett, Cleveland, Ohio; Dr. M. P. Vander-Horck, Minneapolis; Dr. B. Merrill Rickets, Cincinnati, Ohio; Dr. H. W. Blanc, Sewanee, Tenn.; Dr. J. V. Shoemaker, Philadelphia; Dr. J. H. Bloom, Louisville, Ky.; Dr. H. W. Stelwagon, Philadelphia; Dr. J. C. McGuire, Washington, D. C.

Communications, notices of papers, etc., should be sent to the Secretary, Dr. W. S. Gottheil,
25 West Fifty-third Street,
New York City.

Miscellaneous.

Some Current Fallacies.—In concluding an article on The Course of the Inferior Laryngeal Nerve, in the *Lancet* for March 11th, Mr. W. Ramsay Smith, of Edinburgh, mentions a number of theoretical assumptions that are easily overthrown by practical tests. He says:

"Theories of this description are very fascinating. They are often wrong, but criticism of them not infrequently points the way to a truer explanation. The works of old masters in science, medicine, and philosophy are full of them, some fanciful in the extreme, some evidently erroneous, some seemingly true, yet all requiring rigorous testing. To mention many of those theories would be tedious and useless. I may take, however, from my note-books, a few instances of theories taught even now that have probably as little foundation in fact as the theories that have been exploded ages ago:

"1. Normal knock-knee in women is said to be due to the greater width of the pelvis. Let it be

granted that the pelvis is wider in women, as it is granted that women possess ovaries—how does width of pelvis explain knock-knee? Does width of pelvis explain the greater degree of knock-elbow in women?

"2. In the act of swallowing, the lower jaw, it is said, is firmly applied to the upper. This is said to be necessary in order that the muscles attached to the lower jaw may have a fixed point to act from. But swallowing is possible without fixing the lower jaw to the upper. It is not possible, however, without fixing the tongue.

"3. Spigelius says that the function of the buttocks is to form a cushion on which the body may be softly supported, for the purpose of divine cogitation. Is there any real advance on this theory?

"4. It is taught that the great preponderance of muscles inserted on the inner aspect of the tibia is to be explained in relation to the unscrewing of the knee joint at the beginning of the movement of flexion. I have examined this theory in the *Journal of Anatomy and Physiology*, and have ventured an explanation that may also cast some light upon the function of the buttocks.

"5. The 'reflex plan' in the knee in cases of hip-joint disease is explained by the fact that the obturator nerve supplies both. Is this a real explanation? In this connection I may state that I have found that stimulation of a spot of skin about an inch to the left of the external occipital protuberance is associated with a corresponding sensation at the same instant, referred to a spot just over the tip of the twelfth rib on the left side.

"These are only a few instances, but they illustrate how very necessary it is to apply a little logical criticism to every theory in anatomy and physiology, however well established it may appear to be. Medical science appears to suffer more from want of well-trained minds than from want of the spirit of investigation."—*N. Y. Med. Journal.*

A Musical Anus.—At a recent meeting of the French Surgical Congress, in Paris, a man was exhibited who for some time had been earning a livelihood by playing musical airs with his anus in various places of public amusement. A history of this case, and a study of his methods, appear in a recent issue of the *Semaine Medicale*, by Dr. Baudouin. While still a boy, this person noticed that when bathing he could, by deep inspiration, draw water into his bowel. His friends encouraged him to cultivate his talent, which he did so assiduously that before many years he could not only draw up large quantities of water and expel it again with great force, but he also became able to draw in air. By alternately drawing in and expelling air through the anus, he imitated a number of musical instruments—as a trombone and a violin—and a bass voice. He is able to play different tunes, so that they may be readily recognized. Physical examination reveals nothing abnormal. The aspiration is caused by a remarkable voluntary control of the lower bowel and anus, combined with the power to create a negative tension in the abdomen by well-trained muscular action. The different tones are produced mostly by an artistic expulsion of the air through the anus, aided by the movements of the buttocks. The lower bowel is so well under his command that he can entirely empty it at pleasure, thus avoiding any disagreeable odor during his performances.—*N. Y. Med. Times.*

Emergencies.—*Accidents in giving anæsthetics.*—Tincture of digitalis hypodermically; draw out the tongue and see that respiration is not mechanically impeded; invert the patient quickly and temporarily: use forced respiration promptly; apply external warmth and stimulation; avoid the exhibition of alcohol.

Angina Pectoris.—Inhalation of chloroform, or a few drops of nitrate of amyl; 1-100 grain of nitro glycerine internally; placing the feet in hot water; mustard to the præcordial region; dry cup between the shoulders; hypodermic injections of morphine and atropine; administration of stimulants and anodynes.

Apoplexy.—Elevate the head and shoulders; if pulse is moderately strong and the brain congested, bleed from the arm freely, sixteen ounces or more; electerine (one-sixth grain) or croton oil, two drops in a drachm of sweet oil or glycerine; cold to the head by means of an ice bag.

Asphyxia.—In drowning, hold the patient's head downward for a few seconds. In hanging or choking, bleed from the jugular. If there is obstruction to passage of air through the mouth or nose, open trachea. Artificial respiration at once, and to be continued. Friction, warmth, warm bath (100°), ammonia to nostrils, galvanizing of phrenic nerve.

Asthma, Spasmodic.—Hypodermic of atropine into the nape of the neck; inhalation of smoke of stramonium leaves; fluid extract of nux vomica, internally, alcohol, ether, chloral, opium; inhalation of chloroform cautiously administered.

Colic, Gall.—Morphine, hypodermically; inhalation of chloroform; hot applications to the abdomen.

Coma.—Dark room; head high and cool; head shaved; low diet; croton oil; if due to compression, antiseptic trephining; if due to anæmia, pilocarpine and hot baths.

Heat Stroke.—Remove clothing, sprinkle with water, cold cloths to the head, hot cloths to the feet; antipyrin; bleeding in robust subjects. After temperature is reduced give alcohol and diffusible stimulants, hypodermically if necessary.

Hiccough.—Acid drinks, cold douches, ether or chloroform internally, externally or by inhalation; musk, opium, antispasmodics.—*Medical and Surgical Reporter.*

A Post-mortem Phenomenon in Cholera.—A Vienna physician, Dr. Frey, states that the supposed burial alive of patients apparently dead from cholera may be explained by the fact that the corpses of those who have died from the disease are for some time subject to convulsive movements of some muscles, or even of whole groups of muscles. Prof. Eichhorst also relates that on one occasion he had left a patient for dead, when, three hours later, he was told that the dead man had revived. He found that the muscles of the upper arm were giving, short, quick motions, following each other rapidly, which were interrupted by contractions of the whole group of muscles, whereby the forearm was visibly contracted. The fingers were distinctly observed to be moving, as though playing a piano. It was only after three hours that the movement of the muscles ceased.—*Hospital Gazette.*

Black Eye.—There is nothing to compare with a tincture or a strong infusion of capsicum annuum,

mixed with an equal bulk of mucilage or gum arabic, and with the addition of a few drops of glycerine. This should be painted over all the bruised surface with a camel's hair pencil, and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted, the treatment will invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic, sore, or stiff neck.—*Med. Times.*

SURGICAL SOAP.—Dr. Horace Tracy Hanks, in a late issue of the *Medical Record*, says:

In view of the fact that to-day cleanliness is next to godliness to every good surgeon, and that time is a desideratum which cannot be ignored in preparing ourselves for our surgical work, I believe that the accompanying formula for a liquid soap mixture meets the above indications better than any preparation of soap in the market. I have been experimenting for over a year, and have found this agreeable, effective, and economical. It cleanses the hands and removes the accumulations under the nails in the shortest possible time, quicker than anything else I have ever tried. The alcohol assists in this, while the glycerine renders the skin soft after the hands are dried. The strong alkali of the green soap may possibly act as a mild germicide, but it should not be depended upon to the exclusion of those fluids which are known to be absolutely germicidal. In the formula I have given, preferably to myself, oil of rose geranium for a scent to overcome the sometimes disagreeable fishy odor of the green soap, but the same quantity of oil of wintergreen, or peppermint, or bergamot, as preferred, will serve equally well:

3 parts best commercial green soap.
1 part 95 per cent alcohol.
1 part glycerine.
1 part water.
1 drachm oil rose geranium to each part of alcohol.
—*Med. Summary.*

LOCAL ANÆSTHESIA is said by Dobisch to be readily produced in about one minute by a spray of menthol, one part; chloroform, ten parts; ether, fifteen parts. The anæsthesia continues from two to six minutes.

THE INTERNATIONAL MEDICAL CONGRESS.—Concurrently with the congress which will meet in Rome on September 24th there will be opened an Esposizione Internazionale di Medicina ed Igiene (International Exhibition of Medicine and Hygiene), an important feature in which will be the Alimentary Section, including the most favorable specimens of Italian wine growing. As the International Medical Congress will hold its sittings in the Policlinico, so the exposition will be accommodated in the magnificent Palazzo delle Belli Arti (the "Burlington House" of Rome), which, situated in the Via Nazionale, will be central enough to be convenient for the visitors, while not too far from the Policlinico. The use of the palazzo in question was kindly granted to the committee of the exposition by the Communal administration, which even thus early has been coöperating with the municipio and the government itself to make all the arrangements for the congress as perfect as possible. Another request addressed by the committee to the Communal administration has not yet received a definite reply—the request that the gardens in front of the Quirinal might be placed at the committee's disposal. If the reply be in the affirmative—and no effort will be spared on either side to make it so—then the visitors may be congratulated on a privilege truly enviable, that of enjoying the noblest of views from terraces of great historic interest, under the shade of trees, which will be doubly grateful in the still, warm air of the early Roman autumn. The artistic and natural advantages of the Eternal City will indeed be so utilized by the central committee as to make the eleventh International Medical Congress unique in its attractiveness, a result to be expected from its ruling spirit and actual President, Dr. Guido Baccelli, who, as Minister of Public Instruction, brought to light the Hall of the Vestal Virgins and devised the far-famed "Passeggiata Archeologica," or Archæological Promenade.—*Lancet.*

WOMEN AS PHARMACISTS.—It is stated that the Bohemian Club for the emancipation of Women has addressed a petition to the Austrian Minister of the Interior, asking that women may be allowed to study pharmacology and practice as apothecaries. If the petition be granted, the club intends to arrange special classes for women desirous of devoting themselves to the calling. In Austria the apothecary or pharmacist is regarded as a member of a learned profession, and, as in Germany, his business is strictly under government control, the number of pharmacies being limited, and annual visits made by professional inspectors to ascertain the state of efficiency of the establishments.—*Pharmaceutical Journal and Transactions.*

EXAMINATION OF THE RECTUM IN INSURANCE CASES.—Dr. Mathews, of Louisville, raises an important question in an American contemporary in regard to the necessity of examining the rectum in insurance cases. He records five cases bearing upon this subject, one of which may be quoted. A patient was referred to him for an opinion with respect to some disease about the rectum, supposed to be hæmorrhoids. An examination was made, and a large nodule was detected with the finger about three inches and a half up the rectum. The man appeared to be in excellent health, but despite this fact, there was very little doubt but that the disease was malignant. Some simple treatment was recommended, and the patient left for a long trip, and was absent several months. On his return he again presented himself, stating that he felt much better and suffered in no way from his disease. On examination, however, the ulceration was found to have spread considerably. Shortly afterward, nothing daunted, the patient made an application for insurance and was accepted for a policy of $10,000. In less than six months the man was dead from extension of the growth and perforation.—*Pacif. Med. Jour.*

DEATHS UNDER CHLOROFORM.—The stream of deaths from chloroform during inhalation still flows on in undiminished volume, and while much is said and written about the methods of restoring collapsed patients, there is little about how to prevent collapse. It has not yet come home to doctors generally that the want of oxygen is the direct cause of the collapse, but we notice a practical suggestion of Dr. G. H. Nicholson, of Liverpool, which may lead to some good. He advises a combination of oxygen with the

chloroform-vapor, and says that this keeps up the blood-pressure and maintains respiration in a way that gives confidence to the operator. This is well worth trying.—*The Chem. and Druggist.*

INCOMPATIBILITIES OF ANTIPYRINE.—The following drugs are chemically incompatible with antipyrine, precipitating it from an aqueous solution: 1, carbolic acid in strong solution; 2, tannin and substances containing it; 3, tincture of iodine; 4, the chlorides of mercury. The following decompose antipyrine when rubbed up with it in a dry mortar: 1, calomel, which forms a toxic compound with antipyrine; 2, *b*.naphthol; 3, chloral, which with it forms an oleaginous liquid; 4, bicarbonate of sodium; when this is mixed with antipyrine an odor of acetic ether is given off; 5, silicylate of sodium, which, like chloral, forms an oleaginous mixture; 6, the salts of quinine and of caffeine, the solubility of which is increased by antipyrine.—*Gazette des Hopitaux.—Med. Record.*

THE COMMITMENT OF LUNATICS.—Dr. Carlos F. MacDonald, in the *New York Times* of November 27th, 1892, reiterates the often expressed statement of American physicians of hospitals for the insane, on a purely sensational aspect of this subject as follows:

The assertion so often flippantly made that almost any two doctors can be induced for a consideration to certify to the insanity of a sane person in order to enable his relatives to get him out of the way, does the medical profession a great injustice. During the more than twenty years that I have been professionally connected with the hospitals for the insane, also in my official capacity as the medical member of the Commission in Lunacy, I have had occasion to examine thousands of cases in custody—either at the request of others who thought them sane, or frequently at the solicitation of patients themselves—and I have yet to find a single case of whose insanity I had any reasonable doubt, except in certain convalescent patients who were about ready to be discharged as recovered. I have, however, known of cases in which the commitment papers were defective, and also, though very rarely, instances of mistaken diagnosis, in which the delirium of fever, alcohol, etc., has been mistaken for insanity proper, and the case sent to an asylum. But, to the credit and honor of the medical profession, be it said, I have yet to find an authenticated instance of a sane person being certified as insane and incarcerated in an asylum through fraud, corrupt collusion, conspiracy, or wrongful intent on the part of medical men.—*Aliienst and Neurologist.*

THE NATURE OF FISH POISON.—Some persons exhibit an idiosyncrasy to being poisoned by fish, while to others no harm seems to happen under any circumstances. Arnstamoff, has observed eleven cases of poisoning in human beings after eating salted salmon; of these five died. An examination of the fish showed a peculiar soft consistency, but no putrefaction. A large number of living microörganisms were seen under the microscope, and these bore a strong resemblance to typhoid bacilli. Symptoms of poisoning developed in the patients in ten to twenty-eight hours after ingestion of the fish, but the amount ingested had no influence on the rapidity and intensity of the toxic symptoms. Complaint was made by the patients of general weakness, abdominal pains, dyspnœa, mydriasis, diplopia, vertigo, dryness in the mouth, dysphagia, constipation, and a lowered temperature. The post-mortem signs in the fatal cases were very indefinite, and if anything only pointed to death from asphyxia. Bacteriological and microscopical examination of the various organs afterward revealed the presence of the same microbes which had been detected in the fish. Pure cultures made with these microbes were injected into nineteen rabbits, two dogs and two cats. The latter four animals recovered, but only after severe illnesses, while all the rabbits succumbed. Both in the symptoms presented during life, and in the presence of the microbes in the organs after death, the toxic effects observed in the animals were identical to those noticed in the patients above referred to.—*Food.*

BREAD AND DYSPEPSIA.—The conclusion that wheat bread is unfit for dyspeptics, sometimes jumped at because ill effects are noticed to follow its use, is erroneous. On the contrary it has been pointed out by Bouchard and others, that farinaceous food is peculiarly adapted to some dyspeptic patients. It is the microbes in the starch, which are capable of producing irritating acids that cause the trouble. To avoid this, Bouchard recommends that only the crust or toasted crumb of the bread be used by dyspeptics, particularly those whose stomachs are dilated. The reason of this is explained by the fact that baking temporarily, though not permanently, arrests the fermentation of dough. When it is again heated by the warmth of the stomach the fermentation is renewed. In cases where the bread is toasted brown through the fermentation is stopped permanently.—*Food.*

HOW TO KEEP POLISHED STEEL FROM RUSTING.—Surgical instrument makers, needle manufacturers and others frequently complain of the annoyance and loss caused by rusting of polished steel. A device for the prevention of rust based on the well-known affinity of calcium chloride for moisture has recently come to our notice. This consists in placing a few lumps of calcium chloride in a small glass funnel resting in a narrow neck bottle. This is placed in the case or closet containing the articles to be preserved, and will speedily absorb every trace of moisture; polished steel instruments exposed for months in a case (not necessarily air tight) were found at the end of that time quite free from rust specks. The arrangement of bottle and funnel permits the liquefied portion of the calcium chloride to trickle from the funnel into the bottle, drop by drop, leaving the salt exposed so that it continues active until it is entirely dissolved. —*Record.*

MALE HERMAPHRODITE AS A WIFE.—Kochenburger (St. Louis *Med. and Surg. Jour.*) reported to the Berlin Obstetrical Society a "woman," aged 35, who had been married ten years. She was accustomed to regular connection, which gave no particular pain, but was unattended by orgasm on her part. The menses had never been seen. The vagina was a blind canal not quite two inches long, and no other pelvic organ could be detected on exploration. In each labium were two cylindrical bodies, which Dr. Martin excised as they caused pain. On microscopic examination, the two bodies proved to be testicle and epididymis. The subject was a transverse male hermaphrodite.

Pamphlets Received.

Ripening of Immature Cataracts by direct trituration. By Boerne Bettman, M. D. *Annals of Ophthalmology and Otology.*

Bloodless amputation at the hip joint by a new method. By Michael Senn, M. D., Ph. D. *Chicago Clinical Review.*

Laceration of the Posterior Crucial Ligament of the Knee Joint. By A. E. Hoadley, M. D. *Chicago Clinical Review.*

Wit and Humor.

The Doctor's Dream.

I am sitting alone, by the surgery fire, with my pipe alight, now the day is done;
The village is quiet, the wife's asleep, the child is hush'd, and the clock strikes One!
And I think to myself as I read *The News*, and bless my life for the peace upstairs,
That the burden's sore for the best of men, but few can dream what a doctor bears;
For here I sit at the close of a day, whilst others have counted their profit and gain,
And I've tried as much as a man can do, in my humble manner to soften pain:
I've warned them all, in a learned way, of careful diet, and talked of tone,
And when I have preached of regular meals, I've scarcely had time to swallow my own.
I was waked last night in my first long sleep, when I crawled to bed from my rounds dead beat.
"Ah, the doctor's called!" and they turned and snored, as my trap went rattling down the street.

I sowed my oats, pretty wild they were, in the regular manner when life was free,
For a medical student isn't a saint, any more than your orthodox Pharisee!
I suppose I did what others have done since the whirligig round of folly began,
And the ignorant pleasures I loved as a boy—I have pretty well cursed since I came to be man,
But still I recall through the mist of years and through the portals of memory steal
The kindly voice of a dear old man who talked to us lads of the men who heal,
Of the splendid mission in life for those who study the science that comes from God,
Who buckle the armor of Nature on, who bear their breast and who kiss the rod.
So the boy disappeared in the faith of the man, and the oats were sowed, but I never forgot
There were few better things in the world to do than to lose all self in the doctor's lot.

So I left the life that had seemed so dear, to earn a crust that isn't so cheap.
And I bought a share of a practice here, to win my way, and to lose my sleep;
To be day and night at the beck and call of men who ail, and women who lie;
To know how often the rascals live, and see with sorrow the dear ones die;
To be laughed to scorn as a man who fails, when Nature pays her terrible debt;
To give a mother her first born's smile, and leave the eyes of the husband wet;
To face and brave the gossip and stuff that travels about through a country town;
To be thrown in the way of hysterical girls, and live all terrible scandals down;
To study at night in the papers here of new disease and of human ills;
To work like a slave for a weary year, and then to be cursed when I send my bills!

Upon my honor, we're not too hard on those who cannot afford to pay.
For nothing I've cured the widow and child; for nothing I've watched till night turned day;
I've earned the prayers of the poor, thank God, and I've borne the sneers of the pampered beast,
I've heard confessions and kept them safe as a sacred trust like a righteous priest.
To do my duty have never I sworn, as others must do in this world of woe,
But I've driven away to the bed of pain, through days of rain and through nights of snow.

* * * * * * * *

As here I sit and I smoke my pipe, when the day is done and the wife's asleep,
I think of that brother-in-arms who's gone, and utter—well, something loud and deep!
And I read *The News* and I fling it down, and I fancy I hear in the night that scream
Of a woman who's crying for vengeance! Hark! No, the house is still! Its a doctor's dream!

—*Punch.*

Boil it Down.

Just a word to those good doctors,
Who are meditating deep,
On a paper they're preparing,
Full of thoughts too good to keep—
Boil it down.

'Tis not words, but facts, we're wanting;
Therefore prune and pare with pains
Your scholastic evolution
Till an essence pure remains—
Boil it down.

Let the meeting at Milwaukee
Be a feast for every soul
Who attends. And let the papers
Be as brief as Moses' scroll—
Boil them down.

You'll remember former meetings,
There were papers, less or more,
Hardly worth the time to listen—
We have all been there before—
Boil it down.

Welcome every fresh advancement,
Hail, each new discovered fact,
But in writing a description
That attention will attract—
Boil it down.

And remember that discussions
All of interest all agree;
So your paper should invite it;
Make it short as well may be—
Boil it down.

W. E. Ward, M. D., *in Jour. A. M. A.*

A Cranky Patient.—Doctor (to patient)—"I do not wish to frighten you, but if you have no objection I'd like to call in a couple of my brother physicians."

Irascible Patient—"All right! If you need any assistance in murdering me call in your accomplices."—*Texas Siftings.*

"Are there too many doctors?" asks an exchange. "No, there are not half enough; but there too many men pretending to be doctors who are not."—*Texas Siftings.*

Doctor—Ben, what's your face so bunged up for?

Ben, (sadly)—Dat fool George Williams done it; I was at de cake walk las' night, and all I say to his gal was, "good ebnin, Miss Annie, you's lookin' quite pregnant dis ebnin." What make him hit me, doctor?

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

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ORIGINAL ARTICLES.

Strangulated Umbilical Hernia.

WITH REPORT OF CASE OPERATED UPON SUCCESSFULLY.

By M. S. MARCY, M. D., Peoria, Ills.

Read before the Military Tract Medical Association, at Canton, Ills., October 17 and 18, 1892.

Umbilical hernia may be defined as being a tumor formed by the displacement of a viscus or a portion thereof, which has escaped from its natural cavity and projects through the umbilicus. When it is remembered that in the development of the fœtus the last part of the petitoneal cavity to close into a shut sack is at the naval and that arrest of development is liable to occur at any time during gestation, the only astonishment is that thousands more of the human race are not born with umbilical hernia.

Congenital umbilical hernia comes next in frequency to inguinal hernia, or about five per cent of all hernias are umbilical.

It is somewhat surprising in looking up this subject to notice how meager are the writings and reports of strangulated umbilical hernia in our works devoted to surgery.

In an elaborate paper by Birkett thirty-seven cases are collected of which eight died without intervention, and twenty-nine were operated upon, all locally. Of these twenty-nine sixteen were fatal and thirteen recovered. In two cases coming under his observation, William Thorburn, of the Manchester Royal Infirmary, has substituted laparotomy for local herniotomy with satisfactory results.

Vulpius has collected sixty cases from the literature upon the subject, with a mortality of 18.3 per cent, while seventy-two cases of the non-strangulated class are collected with no fatal cases.

Vulpius concludes from this report that surgeons should have no fears in performing an early herniotomy in strangulated hernia.

H. Pelkington relates a case of large umbilical hernia in which spontaneous laceration of the integumental covering had occurred, with protrusion and strangulation of the intestines. The tumor measured two feet, two and one-half inches in circumference, having irregular pouches. At the umbilicus there was a rent of the skin through which protruded more than eight inches of intestines. This wound was enlarged; the intestines returned and the wound closed by quilled sutures. The patient recovered.

In a letter received from Dr. N. Senn a few days ago, he states that he has recently operated with perfect success on two cases of enormous size, for the radical cure of hernia in this locality, both very obese women.

The aperature through which the omphalo-enteric duct of the yelk sac or umbilical vesical passes to the intestines, with its omphalomesenteric vessels, is occupied in its upper part by these structures bound together by the reflected tube of amnion, while the lower part is occupied by the urachus or tube of communication of the allantois sac with the bladder, and with it passes upward from the pelvis in front of the peritoneum, by the placental (afterward the hypogastric branches of the internal illiac arteries) and, passing downward from the liver, by the umbilical or placental vein.

About the third month of intrauterine life, the umbilical vesical and the omphalo enteric duct, with its vessels begin to shrink and finally disappear. In case of slow or late development a thread-like pedicle can be seen, even at the full period of gestation. Soon afterward the tubes of the urachus occupying the lower part of the umbilical opening shrivel and close up; and here again we occasionally find a delay in development. and at birth there may be a patulous opening at the naval, through which a little urine may trickle. In more decided cases of very early arrest of development in this region, we may have produced the deformities known as ectopia, vesical and epispadias. The hypogastic arteries and umbilical vein persist until birth is fairly accomplished and sometimes the reflected tube of amnion is found to pass into the umbilical cord and to contain a portion of small intestines even at birth.

Notwithstanding the frequency with which we find the umbilicus remaining open, nature has made a wise provision in the arrangement of the abdominal muscles for closing up this opening after birth. On either side of the opening we have the rectus abdominus, enclosed in the split sheath of the internal oblique, fortified on its posterior by the tendon of the transversalis and on the anterior by that of the external oblique muscle. On the inner side, the sheaths of the two recti muscles are united in the median line by crossing and interlacing fibers, forming the linea alba. At the naval the linea alba is at its widest part, and some of the fibers at this point are arranged so as to surround, in a parabolic curve, the opening of the umbilical vessels. These curves arranged in different directions have strong powers of contraction, and thus assist in closing up the opening. The closure is aided also by the contraction of the recti muscles in expiratory and explosive efforts.

The contraction of the oblique muscles also aids by the cross pull which it exercises upon the decussating fibers at the navel.

The fascia transversalis in the umbilical region, is thin but tougher and with closer fibers than in other parts of the abdominal wall, and it is here blended closely with the decussating fibers of the linea alba. The serous peritoneum is also thinner, tougher and more closely adherent than elsewhere, and thus does it share in closing this opening.

While umbilical hernia of adults may be, and often is, a continuation of the infantile, passing through the naval opening, more frequently they differ in their origin and anatomy, and pass through an aperture close above, or below, or on one side of it.

Usually the umbilical cicatrix becomes involved and by distention is found to partly cover the tumor, but not quite in the center; generally a little below it. Numerous small openings are found near the linea alba, through which pass small branches of the intercostal arteries and nerves. These openings are usually filled up with small nodules of connective or adipose tissue. As the person gets corpulent these nodules increase in size, while the openings in the fibrous network become larger by stretching; then if

the individual gets thinner from any cause, the openings become more patulous and are imperfectly filled by adipose tissue from the subperitoneal fat. Any violent expiratory exertion, such as a cough, straining or forcing effort, or during pregnancy, parterition or constipation, may drive a portion of peritoneum into the opening and a small sac is formed. Umbilical hernia in adults has a thin and closely adherent sac. The contents of an umbilical hernia in adults, is most always omentum thickened and hardened by inflammatory effusion. Again the colon is found in the sac, in rarer cases, the stomach duodenum, liver, gall-bladder, cæcum, sigmoid flexure, or even the uterus, ovaries or bladder, may be found in the sac. In children umbilical hernia usually contains small intestines, with a covering of omentum. The point of strangulation in an adult umbilical hernia, is most frequently at the lower part of the neck of the sac.

The diagnosis of umbilical hernia should not be difficult in children. Dropsy of the fundus, carcinoma, growing from or near the navel, and cystic growths are about the only troubles that might cause an error. In adults it is more likely to be taken for fatty tumor, but may be distinguished by its compressibility and by its getting larger or smaller as the patient changes position; also by its tympanic sound or percussion, when it contains bowel.

Congenital umbilical hernia in children under puberty, is rarely strangulated. The tendency is naturally toward a cure and requires only the aid of proper and efficient pressure to accomplish it.

Not so, however, in the adult, especially in women with large, fleshy abdomens. Many women go through life with an umbilical hernia, which they manage to reduce and keep in place a part of the time by exerting pressure with the various blocks, pads, bandages, etc., but very few are ever cured of their trouble in this manner. In corpulent persons the hernia often insinuates itself beneath the skin within the adipose tissue; when this is the case very little enlargement can be noticed. Such a condition is peculiarly dangerous if strangulation takes place, from the liability to overlook the real trouble and hence mismanage the case. The late Dr. S. D. Gross speaks of such a mistake being made by a medical friend of his, a man of great intelligence, who never suspected the true nature of the disease, until it was revealed by dissection after death. It would be well then for us to bear this important fact in mind when we meet obscure abdominal troubles. The diagnosis of strangulated umbilical hernia having been established, every effort, with all due gentleness, under an anæsthetic, should be made to reduce the hernia, and failing in this, an operation should be made without delay. The prognosis in these cases must be very grave, and should be guarded. After it has been decided that an operation is the only means of offering the patients a chance for their life, the situation should be explained briefly to the friends and patient, and while holding out all hope possible, the seriousness of the operation should not be withheld, not only for the sake of the patient, but that the surgeon may not receive censure for making promises that he may be unable to fulfill.

In speaking of the operation we will detail the case referred to at the head of this paper. Mrs. B., living in the country, married, aged about thirty-two years, weight 240 pounds, rather short and with large fleshy abdomen—mother of one child two and a half years old, had been troubled, more or less, with umbilical hernia, since the birth of her child. On August 25th, 1892, after returning from the water closet, where the bowels moved freely, she was taken suddenly with severe pain in the bowels.

Dr. J. W. Connelly, the family physician, was immediately sent for. He found her suffering great pain, vomiting, and with a tumor projecting from the umbilicus about the size of half of an orange. After an unsuccessful attempt at reduction, council was sent for, when it was decided to aspirate the tumor, as fluid could plainly be felt. About half a pint of fluid was drawn off, greatly to the relief of the patient; the tumor at once collapsed, and sank below the level of abdomen, only to appear again at the end of six hours. It was again aspirated and relieved the patient. Aspiration was continued every six hours until the sixth day. On the third day the bowels became tympanitic and distended, which continued to increase daily. Opiates were administered and gave temporary relief. The patient grew worse, and began to vomit stercoraceous matter. Becoming alarmed the family prevailed upon the patient to submit to an operation, which she had refused heretofore.

After explaining the seriousness of an operation, and speaking a few words of comfort to the patient, on August 31st, the writer, ably assisted by Dr. Sloan of Elmwood, and Drs. Connelly and Lobaugh, of Farmington, began the operation. The operation was done under as good antiseptic measures as possible, at a farm house. The largest and best room in the house was selected; the instruments placed in boiling carbolized water; the operators' and assistants' hands thoroughly cleansed. The patient was brought in and placed on the table; lower limbs covered with a blanket, and Dr. Connelly administered chloroform. The patient was but very little excited and received the anæsthetic kindly. The abdomen was washed with soap and carbolized water. The last effort to reduce the hernia by taxis was then made, but failed.

Everything being ready an incision was made about six inches in length in the median line, extending from the tumor downward. The adipose tissue was fully six or eight inches in depth before we could reach the stricture in the linea alba. The sac was carefully opened on a grooved director and the tumor exposed, which proved to be a thickened portion of omentum and a knuckle of small intestine. The finger was with difficulty then introduced into the ring, and with a blunt pointed bistory the stricture was divided. Quite a quantity of small intestine escaped through the opening; towels wrung from hot corrosive chloride water (1 to 2,000) were placed over the escaped bowel, and held by an assistant. The strangulated gut was then drawn carefully out and examined. About eight inches of it was very dark, but after applying sponges wrung from hot water, it soon began to grow lighter in color, and it was decided that excision would not be necessary. Strong adhesions had taken place in the knuckle of the gut, and it was thought best to separate them with the fingers, which was carefully done. Venous hæmorrhage at once became very profuse. Sponges were placed underneath to prevent the blood from entering the abdomen cavity, and an effort made to suppress the hæmorrhage. An attempt was made to ligate some of the larger vessels, tortion was also

resorted to, but failing in these methods, compression with sponges wrung from hot water finally checked the hæmorrhage. While the free hæmorrhage delayed the operation for a short time, it doubtless was an advantage by relieving the congestion. A portion of omentum was found to be thickened and very much congested, hence was ligated and cut off with blunt scissors, and afterward stitched fast to the lower cut edge of the hernia opening.

After all hæmorrhage had ceased, the protruding bowels were thoroughly cleansed with hot corrosive chloride water and gently replaced to their proper position. The abdominal cavity was then flushed with very warm carbolized water, until the returning water was clear. Acting on a suggestion made by my friend, Dr. O. B. Will, in a case of ovariotomy a short since, as much water was allowed to remain in the abdominal cavity as it would retain. This not only acts as a powerful stimulant to the circulation, thereby assisting in resisting shock, but dilutes and renders aseptic any discharges that might remain in the abdominal cavity. The opening in the linea alba was then closely stitched with large sized carbolized catgut sutures. A carbolized drainage tube inserted at the lower edge of the opening and the adipose tissue and skin were brought together and united by catgut sutures.

The external wound being cleaned and dusted with boracic acid, adhesive plaster reaching to the sides of patient were applied, oiled silk placed over the wound, carbolized cotton over this and a wide band over all, completed the operation. The patient was placed in bed, hot bottles of water put to the sides and extremities, a hypodermic injection or two of alcohol given, and very soon she rallied and was warm enough to remove the artificial heat. About an hour afterward a hypodermic of morphia and atropia were administered, and the patient had a quiet, peaceful sleep. The patient was left in the care of Miss Alice Sheehan, a very competent trained nurse from the College Hospital of Peoria, and under the supervision of Dr. Connelly, both of whom deserve great credit for their constant and careful watching of the case.

The temperature never rose above 99 degrees. On the evening following the operation, an emulsion of Castor oil was given and on the following day a large amount of offensive fecal matter was passed. This was given not only to unload the bowels, but according to Tait, free catharsis after an abdominal operation is a strong factor in preventing peritonitis.

The dressings were changed on the third day after the operation.

On the sixth day the drainage tube was removed and dressings again changed. The wound healed rapidly and not a drop of pus was noticed. Patient was kept on liquid diet for two weeks, and not allowed to raise her head from the pillow.

From this time the patient made a rapid recovery, and at the present time enjoys her usual good health.

Current Medical Literature.

By Z. Lincoln Whitmire, M. D., Urbana, Ill.

Every class of literature in the course of its lifetime, passes through every possible gradation natural to its class. Many of these points it touches on more than once. The true classical and intellectual type should be the ideal of every writer of medical literature. Taking the medical journals as a type of our current medical literature and basing our judgment on what we cannot dispute the assertion that it has reached a very low, if not the very lowest standard. It is a fact that every few writers are capable of acquiring a true classical style, but we have quite a number of physicians in America as well as in Europe whose teachings and wrintings are the very best so far as knowledge, reseach and study can make them, and that forms the true basis of a scientific treatise. These same men, high in the profession, write for our journals. But when one of these honor a journal with the productions of his pen, dozens of inferior writers do likewise. The whole fault lies in the lack of discrimination. There are too few journals that confine themselves exclusively to the superior grade of productions, and too many that have within their covers innumerable articles of no literary or intellectual value, and written by men whose names are unknown by their nearest neighbors.

I do not wish to be understood to say that only the very best should be permitted to write for the edification of their brother physicians. I believe that writers of every class should have places provided for them. Let us have more journals exclusively for the pens of our best writers and most scientific men; another class of journals for the great number of able and learned, but not quite so prominent physicians whose opinions are respected and whose productions are read with interest, appreciation and for information; then let us have a third class that is open for any and all who can write articles that the editor deems of sufficient interest to his subscribers to be granted space in the journal. Having established his standard, let no journal deteriorate except by way of progression, that some one from the lower rank may take its place. Then medical current literature will be on a par with any class of literature in existence. Every class will find plenty of readers. The reading physician who wants to feast intellectually upon the writings of the profession's leading men, knows to which journal to turn, and in so doing knows that his wants will be satisfied and that he will see nothing unworthy of his mental craving. If he desires to learn of the achievements of the workers in the field of science, he turns to the middle class. And if he wishes to see what some young esculapius has seen fit to inflict upon his brother physicians, he turns to the third class and reads, little dreaming that the writer of that article is probably destined some day to be the leader *par excellence* in the field of medicine and surgery.

As it is now, our journals are filled with writings of all classes. If one wishes to read a dozen first-class articles each month he is obliged to take as many journals, for we have no *strictly* first-class journals; and of all the scientific journals (in proportion to the number in each branch of science) there are more medical journals than any other kind that are scarcely worth the small sum they cost. Give us a better classification and a better standard and we will give you a better price and no less patronage.

"Its Action in Labor." Antikamnia is prompter and more decided in its action in labor than opium, and has none of the unpleasant after effects. It may be continued in smaller doses to control afterpains, and rather favors than interferes with the secretion of milk.—*J. B. Riley, M. D., St. Joseph, Mo.*

Proceedings of Societies.

Philadelphia Academy of Surgery.

Amputation at Hip-Joint—Encysted Cartilaginous Tumor Near Subclavian Vessels: Operation on the Fifth Nerve.

By John B. Deaver, M. D.

Meeting March 6, 1893. The President, Dr. William Hunt, in the chair.

Mr. President and Fellows of the Academy: I first present a case of amputation at the hip joint, done for osteomyelitis of the femur. At the time of the operation the patient was very much depressed from sepsis, consequent upon prolonged suppuration. The only point of interest in the case from an operative point of view is that during the amputation hæmorrhage was controlled by an Esmarch tube applied round the thigh, above the trochanter and along the crease of the groin, being retained here by two pieces of bandage, one passed beneath the tube in front and the other beneath the tube behind, each of which was held by an assistant. An oval flap of skin and fascia was made, and the muscles divided down to the bone by a circular sweep of the knife. The superficial and deep femoral arteries, with their accompanying veins, were next tied separately, as well as those of the muscular branches. The tube was next loosened a little, and the small vessels, as they bled, caught with hæmostats. The tube was now removed, and an incision carried from the external angle of the wound up over the trochanter and into the joint dividing the capsular ligament, when the muscles were carefully separated from the bone and disarticulation completed. The amount of blood lost amounted to two ounces. The advantage this procedure offers over the Wyeth method is in not dividing the femur before the disarticulation is made, and further, that the amount of blood lost is not any greater, and that the vessels not being constricted for so long a time, there is less likelihood of consecutive bleeding.

The tumor I here present is a sarcoma, removed from the side of the neck, which had its origin from the periosteum of the vertebræ. The symptoms were those of laryngeal obstruction, paroxysmal in character and attended by the expectoration of large quantities of mucus. The symptoms of obstruction were not caused by pressure inflicted upon the larynx or trachea, but from involvement of the laryngeal nerves. The same symptoms continued until death, twenty-four hour hours after the operation. The great amount of infiltration around the vessels involved the laryngeal nerves.

The second specimen is a cyst, in the wall of which is a circular piece of cartilage. It was removed from the subclavian region of a man injured at the battle of Appomattox, April 9, 1865. When the accident occurred he was standing under a tree. He was not able to say, definitely, whether the injury resulted from being struck by a piece of shell or by a piece of wood from the tree. The only noticeable trouble at the time of the accident was fracture of the clavicle. From that time to the present a sinus has existed in the neck which patient states has been operated on without success. Upon examination, the orifice of the sinus was plainly seen, immediately above the inner end of the left clavicle, from which was escaping a purulent discharge and through which, upon the introduction of a probe, could be felt, what was believed to be dead bone. Examination demonstrated the presence of a partly movable mass which was thought to be a detached piece of the clavicle which had undergone necrosis. Operation revealed the presence of this cyst; it was attached to the sheath of the subclavian vessels and to the pleura. Examination of the clavicle through the wound showed no trouble other than a slight enlargement at the seat of the original fracture. Examination of the cyst wall demonstrated very clearly the presence of cartilage.

T. M., aged fifty-eight years, white, Irish, slate-roofer; from a child had been very nervous, the slightest excitement or undue exertion throwing him into paroxysms of nervousness. When twenty-eight years of age, had an attack of smallpox which was followed by a weeping sore over the right inferior maxilla. This continued to discharge for six years when it healed. Immediately after the healing of the sore he was attacked with neuralgic pains along the course of the inferior dental nerve. This pain continued at irregular intervals for six years, when he consulted a surgeon, who was supposed to have removed a section of the nerve near the dental foramen. Very little, if any relief followed this operation, when a second was performed, by the same surgeon, one year later; this was followed by relief for one year, when he had another attack of the pain. He now came under my care. I trephined the inferior maxilla over the angle and removed a section of the inferior dental nerve. This was followed by a relief for a period of fifteen months, when the pain again returned. I now opened up the field of the old operation, exposed the proximal end (stump) of the nerve, excised a part therefrom, chiselled away the roof of the remaining portion of the dental canal, and removed the distal portion of the nerve as far as the mental foramen. This was followed by relief for sixteen months, when the pain returned, being referred, in addition to along the course of the inferior dental, along the side of the tongue. I now simply cleared out the field of the old operation, but this was not followed by any marked relief. I again operated, this time taking out a vertical section of the ramus of the jaw as far as the sigmoid cavity, and removed a further section from the proximal end of the inferior dental, and at the same time a section from the gustatory nerve. This was followed by relief. I refrained from taking a section from the interior maxillary nerve immediately after it passes through the foramen ovale, also from performing an intracranial operation, as I am not convinced that these more radical procedures are warrantable until the milder ones have been done without success. I can recall a number of cases, both of neuralgia of the inferior as well as of the superior maxillary nerve, where I have followed this course in relapsing attacks, with satisfactory results, to convince me that a longer period of relief from pain is offered the patient than would result, perhaps, by the more radical operations, removal of the Gasserian ganglion, etc., in the light of the present statistics.

DISCUSSION.

Dr. John B. Roberts: Twice I have had occasion to remove large malignant growths from the neck, and in both cases the result was the same as in Dr.

Deaver's case. In one case, a child, I had to tie the internal carotid artery, and the child died on the second day with symptoms of brain implication. The other case was that of a man with a deep tumor requiring ligation, either of the internal jugalur vein or of a large branch close up to the vein, I now forget which. He died on the fourth or fifth day with symptoms, the origin of which I could not determine. The wound was aseptic and nearly healed. He was found to be breathing very rapidly, and sank in a few hours in a sort of collapse. No autopsy could be obtained.

Dr. J. EWING MEARS: In the case which I reported and to which reference has been made by Dr. Deaver, I removed two and one-half inches of nerve and submitted it to Dr. DeSchweinitz for examination, and the condition found was that of fatty degeneration. I think that all of us have come to the conclusion that operative procedures appear in most cases to be hopeless so far as permanent relief is concerned. It is impossible that from studies in regard to the cause of the condition, we may be able to indicate some method of operation which may prove more successful. Last spring the members of the American Surgical Association were shown in the Massachusetts General Hospital the results in five or six cases of operations upon the second and third divisions of the fifth nerve for neuralgia. In these cases an incision had been made over the temporal region, the muscle cut through and the zygoma divided. By pressing the tissues down firmly the operator was able to reach the second and third divisions as they emerge from the foramena rotundum and ovale. In these cases the relief had extended over three or four years, and in one case five or six years. From the reports which are given in Boston, this appears to be a very successful operation.

If the disease is of central origin I do not see how any operation on the peripheral terminations of the nerves can be of service. Repeated operations, such as Dr. Deaver performed, of course, give temporary relief.

Dr. W. W. KEEN. In the cases were I have had a microscopical examination made the change has been found to be one of sclerosis. In one case there were spots of distinct hemorrhage into the nerve. There were almost macroscopic. I have never seen the inferior dental nerve so large as in this case. That patient had a return of the pain, and a second operation was done. So far as I could determine, a new nerve had formed, and, strange to say, there was a branch of this nerve which went inward through a foramen on the inner surface of the jaw. I saw no such foramen at the first operation. Dr. Dana some time ago published a paper in which he stated that he had found sclerosis of the vessels rather than of the nerve. However this may be, the sclerosis of the vessels or of the nerve is the chief thing, and this is distinctly a senile change. It does not appear in early life, but only later when sclerosis of other organs appear. This being the case, I think that the operation of choice should always be the peripheral operation. I should not think of endeavoring to remove or break up the Gasserian ganglion as a primary operation. I was told the other day that one of Mr. Rose's cases had shown symptoms of return, and this is what might be expected, as the sclerosis begins rather in the periphery and works backward. While medicine offers no benefit in the majority of cases, we can, as a rule, assure the patient that an operation will afford at least one or two years of relief. I presume that some of Dr. Deaver's operations consisted simply in reaming out the connective tissue about the stump of the nerve. This I have done in more than one case, and, although under the microscope no nervous tissue could be found in the material removed, the operation gave as much relief as followed a pure exsection of the nerve. This being the case, it seems to me that we should, as a general rule, endeavor to give relief by such a simple operation, rather than immediately to go to the foramen rotundum or ovale or within the skull and remove the Gasserian ganglion.

Dr. DEAVER referred to destruction of the ganglion as not a serious operation. I should consider it quite a serious operation, although there have not been a large number of deaths. Rose has done it six or seven times with one or two deaths. Andrews four times, without a death. Hartley once, with recovery, and Dr. Roberts once, with recovery. Besides this, two eyes, and possibly more, have been destroyed. It seems to me that any operation involving so much traumatism is to be considered a very serious operation, and should not be undertaken except after the gravest consideration.

Dr. JAMES M. BARTON. We have not yet arrived at the pathology of neuralgia. One suggestion is, that it is due to small aneurisms, which have been found in the diseased nerves. This view is supported by the results of the ligation of the external carotid for this affection. Nussbaum claimed that one-half of the cases are permanently cured.

I can also confirm what has been said by Dr. Keen. The most trifling operation on the nerve, the slightest stretching, even the division of the distal branches is apt to afford temporary relief, and the most serious operation will not do much more.

So rare in my experience, is anything like permanent relief, that I exhibited before this society, a few months ago, as something unusual, a case of neuralgia of the second branch, of thirteen years' duration, in which I removed the nerve at the foramen rotundum, and where the relief had continued for five years. The man is still free from the disease.

DR. THOMAS G. MORTON: I am at present attending a patient, who is now eighty-two years of age, on whom I operated some twenty years ago. After the excision he had entire relief for many years; then had a recurrence of pain, brought on by a ride of five miles in a wagon which had no springs, in which he was severely jolted.

For the last ten or fifteen years, although enjoying robust health, he has at times suffered intensely, and then, again, having entire immunity from pain. Now the suffering is only relieved by morphine injections. Swallowing, talking, any movement of the tongue, touching the skin of the face, or even the beard, provokes "thrusts of pain."

In another case—now more than twenty years since the operation—the patient has had entire freedom from pain. As a rule, sooner or later pain reappears; but in such cases there is no reason why the operation should not be repeated. Benefit is generally experienced from each operation, and for even a measure of relief patients are willing to submit to any treatment.

The Report of a Case of Fracture of Thyroid Cartilage.

By William J. Taylor, M. D.

Surgeon to St. Agnes' Hospital; Assistant Surgeon to the Orthopædic Hospital and Infirmary for Nervous Diseases, Philadelphia.

Charles E., aged forty-three years, a carpenter, was admitted to the surgical ward of St. Angus' Hospital on October 6, 1862, in a semi-conscious condition. He was unable to give an account of the accident, but a fellow workman reported that he had fallen a distance of about twenty feet, from a scaffold upon which he had been working. No one saw him fall but when he was discovered he was unconscious and lying across a heavy piece of wood. When admitted into the hospital, a short time afterward, he was unconscious, could be roused from his stupor, but could give no account of himself. He was very much shocked. The right side of his face was badly contused, his right eye swollen and completely closed. He was bleeding from the nose, mouth, and left ear, and his general appearance was that of a man suffer- from a fracture of the base of the skull. The pupils were equal, and a very careful examination showed this diagnosis to be an error. He had great difficulty in breathing, could not swallow, the saliva ran out of the corners of his mouth, and when he attempted to speak his voice was husky and his articulation very indistinct; he could not speak above a whisper, and only that with the greatest pain and difficulty. There was little or no swelling of the neck, but when he regained complete consciousness he complained of great pain and discomfort in the throat.

A careful examination now revealed a fracture of the thyroid cartilage on the right side, extending from above downward about on a line with the insertion of the thyro-hyoid muscle and about two lines anterior to it. The amount of displacement was very slight, but the mobility of the fragments could be easily demonstrated, and the fragments displaced and replaced again by manipulation with the fingers.

Dr. Smock, the laryngologist to the hospital, examined him very shortly after his admission, and confirmed the diagnosis of fracture of the thyroid cartilage. He reported also a rupture of the tympanic membrane about at the extremity of the manubrium process of the malleus. The nose showed hemorrhagic points on the septum on both sides.

Dyspnœa was pronounced, but there was apparently no emphysema about the seat of the fracture or in the neck. His symptoms were severe, and the pain and discomfort very great, but I did not think them sufficiently so to demand immediate relief.

Dr. White, the resident surgeon, was instructed to make all preparations for instant tracheotomy, and to send for me if the symptoms should increase in severity. He was to use his own judgment, however, and to operate at once without waiting for me to arrive should the necessity arise. No attempt whatever was made to apply a dressing. For some days the bleeding from the mouth persisted, and the difficulty in swallowing and dyspnœa continued, but gradually lessened, and by the end of three weeks was entirely gone. His voice still remained somewhat husky, but there was no longer pain or difficulty in swallowing. The left ear was treated by cleaning out the auditory anal with cotton, and insufflating daily aristol and boric acid.

Multiple Fracture of Both Upper Extremities.

By William J. Taylor, M. D.,

Surgeon to St. Agnes' Hospital; Assistant to the Orthopædic Hospital and Infirmary for Nervous Diseases, Philadelphia.

Margaret C., aged fifty-six years, a widow, and by occupation a monthly nurse, was admitted to my ward at St. Agnes' Hospital on the evening of October 19, 1892, suffering from the most remarkable number of fractures, considering the amount of constitutional disturbance, it has ever been my fortune to see. She was going down the cellar stairway in the dark when she missed her footing and fell to the bottom, some eight or ten steps. From the nature of the injuries she must have put out her hands before her in the hope of breaking the fall.

She was unconscious for a short time, and was then brought to the hospital in a patrol wagon, but recovered sufficiently to walk from the wagon into the receiving ward.

Upon examination it was found that she had received a lacerated wound of the scalp, six inches long and extending down to the bone, and a deep lacerated wound of the lower lip about two inches in length. There was a fracture of the surgical neck of the left humerus and an oblique fracture of the middle one-third of its shaft; a contusion of the left elbow and a fracture of the lower end of both the radius and ulna of the same side. There was a supra-condyloid fracture of the right humerus extending into the elbow-joint, forming a T. A fracture of the upper third of the radius and of the ulna, and a fracture of the lower end of the radius. In spite of this great number of fractures and of the serious lacerated wounds she was able to walk into the hospital, and seemed to suffer comparatively little pain. Her temperature was normal, her pulse good, and there was no evidence of shock such as would have been expected from the nature of her injuries.

There was much difficulty experienced in adjusting and holding in place the different fractures, but with care and patience and plenty of plaster of Paris this was accomplished. Her recovery has been most satisfactory, and she has for all practical purposes full use of both arms.

Such an extensive number of fractures led me to suppose there must have been some serious lesion of the bones, but the most careful inquiries failed to give me any clue to such a state of affairs. She was a large, strong, and, apparently, perfectly healthy woman. She had never before had a fracture of a single bone, neither was there any history of fracture in any member of her family. She was born in Ireland, and had lived there until a few years ago, and had always been in good health and a hard worker.

DISCUSSION.

Dr. H. R. Wharton: Some years ago the President investigated the subject of fracture of the larynx and proved that tracheotomy was indicated, and that patients usually did better after this operation.

I would ask the experience of members in regard to multiple fractures, whether they have found much constitutional disturbance or many cases of sudden death following multiple fracture. My own experience has been that generally patients do well. Last summer I had under treatment a boy six years old, who had fallen off of one of the tunnels of the B. & O. R. R., and sustained a compound fracture of the nose,

fracture of both bones of each forearm, and fracture of both thighs about the middle of the shaft. The patient did perfectly well with normal temperature for a week. He was doing well when I saw him at 12 o'clock. In the evening of the same day the resident noticed that his breathing was peculiar, and an hour afterward the patient was moribund. He died of some cerebral complication. I thought that it might be a case of fat embolism which is said to follow fractures. I have seen another patient die very much in the same way with a simple fracture of the femur. No post-mortem was made in either case.

THE PRESIDENT: The conclusion of the paper which I wrote on fracture of the thyroid cartilage was that where emphysema and bloody sputa were present there had been up to that time no recovery where tracheotomy had not been performed. I thought that tracheotomy should be done when the first symptoms were discovered. I found several cases similar to that reported by Dr. Taylor in which recovery followed without tracheotomy.

Dr. THOMAS G. MORTON: Some years ago I saw in consultation a lady, eighty-four years of age, who had gradually during ten years lost her vision from cataracts. Soon after this she sustained in a fall a fracture of both bones of the forearm, the humerus about the middle and the shaft of the femur near the great trochanter. Complete recovery from these injuries following showed such an excellent repair, that six months afterward I operated upon both eyes at the same sitting. Perfect vision followed in each, which continued until her death when in her ninety-seventh year.

THE investigations of Drs. Abbott and McCormick, of the Johns Hopkins University, show that a solution containing 7 per cent of acetic acid is more effective as a germicide than bichloride of mercury.

A BACILLUS PRODUCING GAS IN THE BLOOD VESSELS AFTER DEATH.—Welch and Nuttall (Bulletin of Johns Hopkins Hospital) have discovered a bacillus which develops rapidly in the blood vessels after death, and whose development is accompanied by the production of gas. The presence of gas in blood vessels at post-mortem examinations has frequently been reported; and its existence has been a puzzle, occurring as it may but a few hours after death, unaccompanied by other signs of decomposition. This new bacillus, which has been named by the authors bacillus ærogenes capsulatus, has been cultivated in agar-agar and other media, and only grows if oxygen is excluded. The growth of the cultures is accompanied by the appearance of bubbles of gas.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Joseph Barnes Bacon, M. D.

Joseph Barnes Bacon, M. D., was born near Macomb, Illinois, in 1854, and spent his early boyhood days on a farm. He obtained the rudiments of his education in the country schools of his native place, and afterward at the Macomb College.

Joseph Barnes Bacon, M. D.

He then studied at the Northwestern University, at Evanston, Ill. He studied at the Galveston College, from which he graduated in 1879; and subsequently at the Chicago Medical College, graduating in 1881. He then practiced for four years at Montevideo, Minn., before going abroad. He afterward studied at the University of Heidelberg six months, and the University of Vienna for one year. After returning to this country he again settled at Macomb, Ill., where he pursued a general practice of surgery and medicine for six years. In January, 1892, he removed to Chicago, and was made professor of rectal surgery in the Post-Graduate School of Medicine. He was one of the founders of the Clinical College of Medicine and Specialty Hospital, in which he was made professor of rectal surgery, and Secretary of the institution.

He is surgeon to the Chicago Charity Hospital, member of the Gynæcological Society, the Chicago Medical Society and the Tract Medical Society. He has established himself in a comfortable practice in the Venetian building, 34 Washington Street.

Leprosy in Louisiana.

The *New Orleans Medical and Surgical Journal* editorially claims that leprosy has become an indigenous in Louisiana and calls for the segregation of the lepers. It calls on the State Board of Health and State Medical Society to take the initiative step in

securing legislation which will protect the public and place the unfortunate victims of the scourge under medical supervision. Its arguments and conclusions are based on the result of the investigations of an eminent dermatalogist. That leprosy has developed in Louisiana in cases in which hereditary influences could not be demonstrated is well known. It is to be hoped that some action will be taken by the law makers which will place in the hands of the State the power to stamp out this loathsome evil.

The New City Health Commissioner.

The medical profession of this city heartily echoes the sentiments so strongly expressed in the following clippings from the *Medical Standard:*

The Chicago medical profession is to be congratulated on the fact that a physician, Dr. A. R. Reynolds, succeeds a cheap ward demagogue as health commissioner. Chicago will no longer be the laughing stock of European sanitarians because of the blatant ignorance of its health commissioner. The mayoralty election rendered another great service to the profession by demonstrating that the two most mendaciouslg blatant of its sensation-mongering enemies were politically impotent. These two sheets have warred on every reputable practitioner of any prominence in the interests of advertising charlatans and quacks. Their sinister popular repudiation is a token of public feeling in an encouraging direction.

Abstracts.

Medicine.

"Akinesia Algera."—Under this term Möbius describes an affection of the nervous system characterised by extreme pain upon motion, so that the patient is unable to make any movement whatever. The exact pathological condition which is the cause of this symptom is as yet unknown. It appears only to occur in neurotic individuals, especially in those who are in a bad state of health generally and who are unable to fight against the weakness. The pain is sometimes directly associated with motion, but in other instances follows it, and is experienced not only in the parts of the body which have been moved, but also in other parts, and may finally lead to almost complete loss of motive power, so that the patient is practically paralyzed. In addition to this pain, which is the most prominent symptom, other phenomena characteristic of neurasthenia may develop, but hysterical outbursts have not been observed. Möbius considers that this disturbance may be attributed to inherited degeneration of the nervous system; that, as a rule, it follows upon mental strain in patients prone to neurasthenia; and that it must be regarded as a psychical affection. The condition must, however, be considered as more allied to hysteria than to hypochondriasis.—*Lancet.*

The Prognosis and Treatment of Chorea.—In a lecture on this subject, delivered at the Hospital for Sick Children, Dr. Octavius Sturges said that the great anatomical fact of chorea is endocarditis, which may be rheumatic, or an endocarditis proper to chorea. Most of the fatal cases exhibit rheumatic carditis. The great clinical facts of chorea are that nervous strain is its frequent cause; that girls are its favorite subjects; and that recovery is its almost constant end. A good working classification of chorea—a rough test of its severity—is found in the ability, or otherwise, of the patient to feed herself. As to prognosis, Dr. Sturges remarked that chorea always recovers, or almost always. The duration of an attack is not proportionate to its initial severity. On the whole, the severer cases are the shorter. The treatment Dr. Sturges adopts consists in sufferance, patience, cheerful anticipation, a firm, unshaken purpose, self-reliance—the very same virtues you seek to arouse in the patient. With the vast majority of cases there is no ground for anxiety. The household of the patient must be quieted. It must be explained that not one child in a thousand is permanently injured by chorea, and that insanity is hardly known in connection with it. The movement in chorea should not be violently restrained; ample space should be provided for the fullest movement. The insomnia, an early rather than a late symptom, may yield to strict quiet. If sleep be absolutely absent over a period of twenty-four to thirty hours, it must be procured by narcotics. In chorea of ordinary severity the patient must be kept quiet in bed, and no open notice be taken of movement infirmity. Food should be light, nutritious, and given liberally. A gentle, somewhat free action of the bowels is very important. Dr. Sturges has not found "drill" practice of much service. As to the question of drugs, apart from narcotics (for severe cases) and aperients, Dr. Sturges believes that no drug has a specific action on chorea; even arsenic is in turn losing popularity.—*The Clinical Journal, Practitioner.*

Antipyrin Rashes.—Professor Eichhorst records two recent cases of exanthem produced by antipyrin. In May a soldier, 28 years of age, was admitted into hospital, presenting all the characteristic signs of enteric fever. Three days after admission, large patches resembling measles made their appearance—first over the lateral aspect of the abdomen, on the next day very abundantly on the neck and legs, especially the thigh. The face was only slightly involved; the mucous membranes were free. The rash remained for seven days, and disappeared by gradual and slow paling of the skin without scaling. On seeing it for the first time, Eichhorst considered it as due to antipyrin, and this view, notwithstanding the patient's repeated denial, proved to be the correct one. Only when then rash had paled and almost disappeared, did the patient confess that seven days before admission he had received two powders from a druggist for feverishness. One he had taken; the other was kept, and turned out to be pure antipyrin weighing about seven grains. It is noteworthy that a strong well-developed man should exhibit a very extensive and obstinate exanthem after a single dose of antipyrin; and still more remarkable that it should occur on the tenth day after taking the drug. Under such circumstances Eichhorst speaks of a late antipyrin exanthem. In contrast to this is an observation of an early rash of antipyrin and a recurrence in the same case. The patient was a medical student, 23 years of age, who passed through an attack of enteric fever last summer. Shortly before he was taken ill he was prescribed fifteen grains of antipyrin, and one hour after its administration there appeared an ex-

tensive rash in large patches, which remained but a few hours. Four days later there occurred for the second time a pronounced eruption resembling measles, though the patient had been treated in the interval with phosphoric acid and warm baths; and this lasted several days. The recurrent rash was in small patches.—*Therapeutische Monatshefte Practitioner.*

True Nature of Mercurial Tremor.—Professor Charcot recently delivered at the Salpêtrière an interesting lecture on mercurial tremor. Charcot concludes that there is no such thing as mecurial tremor; and that the intention-tremor, said to be due to poisoning by mercury, is in reality hysterical, occurring in person who have developed, or possibly originated, the hysterical state through close confinement, long hours, unhygienic surroundings, and the over-exercise of limited faculties. Dutil has made a special study of hysterical tremor, and has made careful examinations of five cases of mecurial tremor, so-called. In three there were hemianæsthesia, hysterogenic zones, and hysterical attacks, the latter often the precursor of tremor. With hysterical stigmata, as corroboratory evidence, the diagnosis of such cases is plain. There is a mono-symptomatic hysteria, as well as other forms. In tonic hysterias, in which some poison is the predisposing cause, the nature of the agent seems to exercise some special influence upon its particular kind of manifestation. Lead gives chiefly anæsthesias and paralysis; alcoholism, convulsive crisis; and mercury, in particular, this rare form of neurosis, tremor. This newer view of mercurial tremor alters routine treament. Iodine and vapor baths give way to mechanical tonics—as the douche shower, and pack; to gymnastics and massage; and to nervine tonics.—*The Medical Record.*

The Effects of Acids on the Functions of the Stomach.—1. Acids throw down a considerable precipitate of mucus.

2. They increase the cellular elements of the gastric contents.

3. Their introduction is followed by butyric acid reaction, most marked after hydrochloric acid.

4. Larger quantities of the acids result in a considerable effusion of bile into the stomach.

5. They stimulate the secretion of pepsin, but have no influence upon the secretion of hydrochloric acid.

6. Their long continued administration is followed by marked diminution of the secretion of hydrochloric acid.

7. Even in large quantities hydrochloric acid produces no gastric disturbances. On the contrary, a continued administration of the acid is attended with a feeling of well being.

8. The difference in the effect between acids and the alkaline salt on the gastric functions consists in the fact that the alkaline salts dissolve the mucus and decrease the secretion of pepsin, while the acids precipitate the mucus and increase the secretion of pepsin.

The disappearance of the alkaline salts from the stomach is followed by a decided increase of the hydrochloric action secretion. This does not occur, or only to a slight degree, in the case of acids. Both the acids and salts, in large quantities in continued use, have the same effect in lowering the activity, and finally in destroying the function of the glands secreting hydrochloric acid.—*Jaworski in Centralblatt für Klin. Med.--Milwaukee Med. Jour.*

Sleep Movements of Epilepsy.—Putnam (*Journal of Nervous and Mental Diseases*) suggests that a study of the movements (apart from the mere restlessness of unsound sleep) occurring in some epileptics while asleep may possibly demonstrate that the site in which the discharging lesion originates is indicated by the movements. One patient, who usually had a fit about 10 A. M., was noticed by him to slowly raise her left arm over her head, momentarily hold it in that position, then let it slide down the pillow. The act was repeated several times within a few minutes. No fit occured that night. In a young girl who had been epilepic for ten years definite sleep movements were habitual; the left arm was suddenly drawn up above the head, then let fall. When in a fit the body was drawn to the left side and the left fist rested on the corresponding shoulder. Removal of a layer of cortex from the arm center in the right cerebral hemisphere of this patient was not followed by any benefit.—*British Medical Journal.*

Influence of Ablation of the Spleen on the Microbicide Power of the Blood.—Montuori (*Rif Med.*, February 17 and 18, 1893) has published the results of some observations on this subject. His method was simply to remove the spleen, preferably from dogs and rabbits, and after a given time to test the bactericidal power of the blood of the animal. His conclusions are as follows: (1) Removal of the spleen is followed by a manifestation of a gradual diminution of the bactericidal power of the blood. This power generally remains about normal for the first fifteen days, being gradually lost between the fifteenth and the thirtieth day; (2) after a time varying from two to four months the bactericidal power gradually returns, and is completely restored in about four months; (3) these effects take place more rapidly in young than in old individuals, and more rapidly in rabbits than in dogs; (4) the germicidal substance is in Montouri's opinion of the nature of a ferment; (5) after splenectomy the blood loses not only its germicidal power, but also its power of destroying the corpuscles of other animals introduced by transfusion; (6) the same applies also to the bactericidal powers of the other juices of the body.—*British Med. Journal.*

Symes W. L. On Hiccough.—The writer regarding this as a reflex act believes that the sympathetic connections of the semilunar ganglion convey the centrifugal impressions rather than the phrenic nerve. His reasons are as follows:

The diaphragm appears to contract before the laryngeal muscles, pointing to a closer and more direct communication with the gastric portion of the vagus than even the recurrent laryngeal.

2. The course of the phrenic nerve is healthy, and its respiratory function perfect.

3. The patient has no control over the spasm, while the phrenic is always subservient to one's will.

4. Remedies applied to the origin or course of the phrenic, such as icebags, compresses, blisters, or to the cervical region, etc., etc., have no effect; while those directed to the diaphragm, stomach and solar plexus, are generally curative.

5. The connections between the pneumogastric

and phrenic by means of the third, fourth or fifth cervical nerves, are remote, and if this were the route taken, the impression must travel more than double as fast on the phrenic than it does on the recurrent nerve, since it reaches the diaphragm before the larynx—conditions which are unphysiological.

6. The experiences of Romberg and Bright, which show that direct irritation of the phrenic will not produce hiccough.

7. The existence of a perfect reflex loop between the stomach and diaphragm, which more directly answers the purpose, separate from the function of respiration and beyond control of the patient.

8. It being influenced by the acts of deglutition or vomiting to a greater degree than by any respiratory efforts.—*Dublin Jour. Med. Soc'y.*

To Prevent Cocaine Intoxication.—Parker has discovered that the unpleasant or even poisonous symptoms which occasionally follow the local application of strong solutions of cocaine in the nasal and buccal cavities, may be entirely prevented by combining the drug with resorcin. This combination is also of advantage in utilizing the antiseptic, astringent and hæmostatic properties of the latter drug.—*British Med. Journal.*

The Indications for Lactic Acid.—Lactic acid is of value in the vomiting due to indigestion in newborn babes, and also in cholera and choleriform diarrhœa. It should be employed in very large doses, from three to four drachms in the twenty-four hours. in the green diarrhœa of children it is necessary, before giving lactic acid, to make an exact diagnosis of the nature of the malady. The green stools of infants are either of bilious or microbian organ. It is only in the latter form that lactic acid is beneficial. The green color of the stools, when due to the presence of the green microbes of lesage, persists upon the addition of nitric acid.—*La Revue Medicale. Med. Bulletin.*

On Cold and Warm Applications.—Dr. Silex shows that cold applications (ice or water of 55° F.) on the eye cause a rising of the temperature of the conjunctival sac, and that warm applications of $\frac{95}{115}$° F. (and Priessnitz fomentions) cause a fall of temperature. It seems that the same result was obtained in applications on the abdomen, if they did not last a long time and did not cover too great a portion of the surface. This can be explained by reflex action on the blood vessels of the deeper parts. We can thus understand the usefulness of poultices in pleurisy and also the usefulness of cold Priessnitz fomentations. On the whole, however, the patient himself will still be the best guide for the choice between cold and warm.—*Deutsche Medizinal Zietung.—Times and Reg.*

Treatment of Typhoid Fever.—In the *N. Y. Medical Times*, Dr. M. O. Terry suggests the following:

1. Keep temperature down to about 100° by sponging as often as every two hours, night and day if necessary.

2. Fumigate with sulphur or Spencer's pastiles every six hours. Evaporate oil of eucalyptol, using thirty drops to a pint of water, allowing it to slowly impregnate the air night and day.

3. Teeth and mouth should be cleansed and freed from all impurities with listerine and water (oz. 1-2 to a glass) and the tongue scrubbed several times a day.

4. A compress should be kept constantly over the abdomen in the region of Peyer's glands.

5. Remove the cause if possible and discontinue the water if suspicion gives you any grounds for so doing.

6. Internally give the following: sodii sulphus oz., 1-2; syr. aurantii cort., oz., 4. Sig., one teaspoonful in water three times a day. Other remedies, such as sulpho-carbolate of soda, gels., bapt., listerine in connection with or interchanging. The remedies given should be *antiseptic* and those for *special symptoms* as they occur.

7. Diet: Milk with salt or peptonized, oat meal or cracked wheat strained, orange juice, coca or broma. Later on in the case, eggs, if bowels are not loose, mutton broth and rice. I never give beef tea in these fevers. Whisky and egg with milk in crisis or during convalescence.

8. If necessary to quiet I would prefer chloroform water; chloroform gtt. 30; aquæ, oz., 6. Sig: From a desertspoonful to a tablespoonful, repeating when necessary. This is not only quieting but antiseptic and an antigermicide. Sulfonal may act well in 5 to 10 grain doses, repeating every hour for three hours if necessary.

Treatment of Fever.—This old, but ever new, subject is one in which every medical man must be certainly anxious to be refreshed. It lies at the root of so much of every-day work that any ray of light must be gratefully received. The following conclusions by Dr. Graham Steell, of Manchester (*Manchester Med. Chronicle*), are worthy of note:

1. Attention must in all cases be directed to the normal fever of the disease, and to the accompanying pulse-rate. Only when fever and pulse-rate assume abnormal severity is there place for consideration of antipyretic treatment.

2. Of the methods of antipyretic treatment, that by bathing is unquestionably the best, and the patient should be placed, first of all, in tepid water, which is subsequently cooled. Wet packing is a much less efficacious method. Treatment by antipyretic drugs is the worst method of antipyretic treatment, but notwithstanding is often useful, both employed alone and as an adjunct to treatment by bathing. In hyperpyrexia, treatment by drugs is useless, and cold bathing affords the only trustworthy treatment.

3. The general laws which govern antipyretic treatment appear to be similar, whatever the method of treatment adopted. The author is aware that theoretical consideration may be urged against this statement, but he is speaking from the practical standpoint.

4. There can be no doubt that the severity of a fever in the immense majority of cases may be well estimatad by the resistance which the pyrexia offers to antipyretic treatment. As a general rule, continuous fever offers greatest resistance, remittant less, and intermittent least. The greater efficacy of antipyretic treatment in the later stages of typhoid may be partly so explained. The fact of degrees of resistance to antipyretic treament, corresponding to degrees of severity of the attack, suggests that the course of mild and moderate cases might be greatly shortened by a vigorous adoption of antipyretic treatment.

5. The difficulties in the carrying out of antipyretic treatment by bathing, are so great that the treatment must be reserved in private practice for cases in which

danger threatens from high fever and severity of the general symptoms. Antipyretic drugs may often be used with advantage as adjuncts to treatment by bathing, and occasionally alone. Nevertheless, their use is to be avoided as much as possible.—*Canada Lancet.*

THE ABSORPTION OF IODIDE OF POTASSIUM THROUGH THE RECTUM, AND ITS EXCRETION.—Calantoni (*Deutsche Medizinal-Zeitung*, August 4, 1892) has made a large number of experiments in this line upon men as well as animals, and observed the following results:

1. The absorption of iodide of potassium injected into the rectum is accomplished just a quickly as from the stomach, so that the usual method of applying the remedy can be replaced by introducing it into the rectum.

2. If a still more rapid absorption is desired, it can be obtained by warming the solution to from 91° to 98° F. The warmth produces a slight congestion of the mucous membrane, and in this way favors the absorption.

3. The time within which the excretion takes place is the same as by other methods. With the usual weak solutions the excretion has been entirely completed in from 24 to 30 hours, while concentrated solutions are slowly eliminated in from 38 to 40 hours. —*Therapeutic Gazette.*

Surgery.

A NEW SIGN IN THE DIAGNOSIS OF INTRA-CRANIAL AFFECTIONS.—In the January number of the *Anales del Circulo Medico Argentin*, Dr. Masi has an interesting article describing a new diagnostic symptom. The great importance of thoracic vibrations—their absence or exaggeration is appreciated in detecting diseases of the thoracic cavity. The same vibrations which occur during articulation are conveyed to the base of the skull, and thence to the vertex, where they can be detected as readily as over the thorax. Apply the palm of the hand to the head and once to the thorax, and the vocal fremitus will be as distinct to the one hand as to the other. If this sign, through its variations, can be utilized to help in the diagnosis of intra-thoracic affections, cannot it be likewise utilized in the diagnosis of intra-cranial effections? This is the question which the author tried to solve. A patient was brought to the hospital, who, through injury, sustained a fracture at the base of the skull with ramifications as far as the upper part of the temporal regions on both sides. All the common signs of fracture of the base, such as bleeding and escape of arachnoid fluid from the ears and nose, etc., were present. Over the left temporal region there was found to be depression of about two centimeters in diameter. The patient rallied, and on the eighth day, as the doctor was examining the head, the patient spoke and a distinct fremitus was perceived over the whole head, except over the depressed bone in the left temporal region. This was noticed by members of the hospital staff and regarded as a strange phenomonon, which would, perhaps, enable one to apply it to other brain and skull lesions. In a normal head, therefore, the vibrations should be distinctly perceived over all portions of the skull, but in those cases where there is increased pressure, such as tumors, abscesses, and hæmorrhages, or where there is thickening of the dura or adhesions between the brain and the skull through the dura, or fractures, absence of this vibration would be expected. The author describes the sign as cranial vibrations, and awaits further corroboration of his discovery.—*Buffalo Medical and Surgical Journal.*

BRACHIAL NEURALGIA DUE TO EXOSTOSIS OF THE FIRST RIB.—Verneuil (*Rev. Gen. de Clin. et de Ther.*) reports the following case: A girl, aged twenty, came under his care at the Pitié Hospital in 1884. Five years previously she had begun to complain of numbness in the left arm; a year later she noticed a small tumor in the supraclavicular region, and soon the pain caused by this tumor extended all over the scapular region and the upper limb. On examination a hard tumor was found springing from the first rib, close to the insertion of the scalenus posticus. The subclavian artery and the branches of the brachial plexus were pushed up and compressed by the growth. The latter was removed, and the pain ceased. Six months later the pain returned, and it was found that the tumor had recurred; it was again removed, and the patient seemed to be permanently cured. More than seven years subsequently, however (in May, 1892), she again presented herself, complaining of renewal of the pain. No bony projection could be felt on the first rib, but the cicatrix was tender to the touch, and the pain radiated over the whole arm, shoulder and upper part of the thorax. Ricard, who was doing duty for Verneuil at the time, thinking the brachial plexus had become adherent to the cicatrix, completely freed it therefrom; but this operation was not followed by any relief of the pain. Medication of the most varied kind was employed without avail, and Verneuil was on the point of giving up the case as hopeless when it occurred to him to expose the brachial plexus, and to apply a solution of cocaine (20 per cent) to its branches. This measure proved completely successful; the patient on waking up from the anæsthesia was entirely free from pain, and has not since suffered from it.—*Amer. Prac. and News.*

ANTISEPTIC MANAGEMENT OF WOUNDS.—Sir Joseph Lister delivered an address on the above subject, which appeared in the *Brit. Med. Journal.* The two great principles are: (1) Not to introduce, at the time of operation, material capable of inducing septic changes; (2) to dress the wound in such a manner as to prevent the entrance of septic mischief. With regard to the first point the spray is not needed. If the hands, sponges, instruments the part to be operated upon, etc., are rendered thoroughly aseptic, the operation may be performed with the same simplicity as in former days. Lister contends that for surgical purposes corrosive sublimate is much inferior to carbolic acid in germicidal power. The anthrax bacillus, the staphyloccocus pyogenes aurenus, the tubercle bacillus are all destroyed much more rapidly by carbolic acid 1 in 20 than by perchloride of mercury 1 in 1,000. For the sponges, instruments, hands, and the part exposed for operation, this is the best agent to use. It also has the great advantage of permeating the epithelium freely, a property which the corrosive sublimate does not possess to any great extent; and, if the surface is greasy, does not possess at all. The carbolic acid, on the other hand, acts equally well in such a case. During the operation sponges should be washed out in carbolic acid solu-

tion 1 in 40. Finally, when the operation is over, the wound should be washed with the same strength of carbolic acid solution. The second point is to keep the wound aseptic. An ideal external dressing must contain a reliable antiseptic, stored in the dressing, unirritating and capable of absorbing the blood. The gauze should be first moistened with 1 in 20 carbolic acid. The double cyanide of mercury and zinc is the favorite antiseptic with the author. To this is added some rosolane, or hydrochlorate of mauveine. This dye has the power of fixing the cyanides in the gauze. The dyed powder is added in the strength of grs. xxx. to the pint of carbolic acid solution 1 in 20. The gauze is drawn through this solution and is ready for use. This dressing is both germicidal and inhibitory, and possesses the four requisites mentioned above. Should this gauze become dry before using, it should be moistened in 1 in 20 carbolic acid solution.—*Ontario Med. Journal.*

A Case of Incipient Ischiatic Hernia.—The patient, a woman, aged forty-one, had been suffering for nine days from constipation and fecal vomiting; was admitted into the surgical department of v. Hacker.

A fracture of the left thigh was at first regarded as the cause of the symptoms of strangulation present. Herniotomy, however, revealed no such strangulation. Laparotomy was resorted to on the same day by v. Hacker, who found that near the end of the ileum, about two finger breadths (spannen) of the bowel had passed through a recess of the parietal peritoneum and become strangulated. This recess was found in the left portion of the small pelvis in the region of the incisura ischiatica.

After releasing the strangulated portion of the bowel, and closing the abdomen, the symptoms of incarceration were at once relieved. The patient, however, died on the sixth day of lobular pneumonia of the right lung.

The author was unable to find any cases in literature quite analogous to his, since the anatomical descriptions of such hernia usually place the sac in another position to the obturator and hypogastric arteries than in his case.

Langer's explanation, however, is that every hernia of this nature, which passes through the opening between the incisura ischiatica major and the upper margins of the pyriform muscle, originates, more or less, from internal hernia, and for that reason regards his case as one in its early stages. Until the present time eleven cases have been published under this head, the author's being the first in which the condition was relieved by operative means.—*Centralb. für Chir.—Med. and Surg. Reporter.*

The Treatment of Fracture of the Patella.—Paul Klemm has used the following treatment for the last five years, which he reports in the St. Petersbury *Med. Wochenschrift:*

Soon after the admission of the patient, at and around the knee-joint, massage is used. He places great stress on massage being particularly directed to the central portion of the fracture in order to increase the lymphatic and venous circulation. After the massage the joint is wrapped in cotton and then a dressing of adhesive plaster, which exercises a certain amount of pressure upon the intra-articular extravasation, at the same time keeping the fragments of bone coaptated. The extremity dressed in this manner was then placed in a fracture box and moderately elevated. After three or four days the bandage was removed. From this time on it was massaged daily, and after two weeks passive motions were used, the patient encouraged to elevate the leg with the knee extended. Between the third and fourth week the patient was encouraged to walk around the room with the aid of a cane, and the beginning of the sixth week usually discharged. Bony union was never met with; there was always a tense, fibrous uniting band which, however, did not interfere with the action of the knee-joint. In all cases there was complete active ability to extend as well as flex up to 50°. —*Medical and Surgical Reporter.*

Impotence From Congenital Stricture.—In the *Ft. Wayne Journal of the Med. Sciences,* Dr. E. R. Palmer reports the following interesting case:

Bank clerk came to me with impotence, with the statement that he had never had a proper erection in his life, that he had been under medicine and under urging in the way of becoming self-confident, etc., attempting to demonstrate to himself his manhood. He had completely failed in this, and stated that he absolutely never had any venereal connection with any woman; that he had an abundance of opportunities in this direction, but had never been able to have a normal erection. I made an examination of his urethra, and about one inch and a half inch back I found a stricture that almost completely obstructed the passage. I was able after repeated attempts to introduce a very small bougie. After making a careful examination I made the diagnosis of mechanical obstruction that I believed prevented the inflation of the blood vessels of the glans; and while I was not convinced that it was a stricture properly speaking, still I believed there might be a cure in this case by the spitting of this obstruction, so I with much difficulty passed an Otis instrument believing that the necessity of the case demanded it. After splitting the obstruction freely I was able to pass a No. 32 curved sound without any difficulty, and afterward passed a No. 32 straight sound. This operation was done three or four months ago, and he reports to me that he cannot only command an erection, but has also had satisfactory sexual congress. He is a very intelligent, rather intellectual, well-developed young man who has reached his twenty-sixth or twenty-eighth year, and had this trouble, which was probably due not to stricture, but to a neoplasm of the urethra. Of course the question of removing it by other means as a better surgical procedure is one of considerable importance.

After-treatment of Cases of Abdominal Section.—Christopher Martin (*The Birmingham Medical Review,* December, 1892) in an incomplete paper upon the above subject, supposes an uncomplicated case of ovariotomy in youthful and strong patient, with no adhesions, a good pedicle and no need of drainage tube. The less such a case is interfered with the better. In reference to the dressings, the author thinks they should be of the simplest character. The wound is dried and then dusted with powdered boric acid, a pad of absorbent (gamgee) tissue is laid on the wound and secured with adhesive plaster, and an abdominal binder is pinned over this. Whenever the pad is soiled it should be changed. This dressing is sufficient until the sixth day, when the stitches are re-

moved, and then a strip of lint spread with zinc ointment may be laid over the wound.

The bladder must not be allowed to become overdistended, and when the patient is unable to avoid urine the catheter must be used at intervals of about six hours. The instrument must be kept scrupulously clean, and when not in use must be kept always under water, thus avoiding the complication of a cystitis. In order to prevent tympanitis the nurse should assist the passing of flatus by the introduction, from time to time, of a "flatus tube," when the patient is unable to relieve herself of the accumulation of gas. The style of flatus tube recommended resembles a glass test tube, curved slightly so as to slip easily into the rectum, rounded at the end, and with a large hole on one side half an inch from the end. Such an instrument greased and gently introduced into the rectum will often bring away a surprising quantity of flatus. If no distention occurs, the bowels need not be moved until the evening of the fourth day, when a mild saline aperient may be given. After this the bowels may be moved daily by a soap and water or glycerine enema, if necessary.

In referring to diet, the rule is inflexible that for forty-eight hours the patient must be starved—not even a spoonful of water must be swallowed—and the intolerable thirst, which so often is present, can be allayed by an occasional rinsing of the mouth with warm water. On the morning of the third day after the operation she may have, in small sips, half a tumbler of milk with an ounce of lime water, and about the midday this may be repeated. During the afternoon of the same day some weak tea, with milk, and a little dry toast may be given, and during the evening a small bowl of gruel or arrowroot, with probably a tumbler of milk later during the night. On the fourth day, in addition to this, she may have beef tea or chicken broth during the forenoon, and a little milk pudding, and on the following day fish for dinner; on the sixth day, chicken; on the seventh day, meat; and on the eighth day, fruit and vegetables.

This dietary is obviously intended only for those patients who convalesce without complications. If everything has progressed favorably, the patient may sit up in bed for an hour on the fourteenth day, and get out of bed for an hour on the next day. By the end of three weeks she will be able to take a drive or leave home. Before sitting up the patient must be measured for an abdominal belt, which must be worn day and night, a lighter one being preferable for night use. The patient must be told of the dangers of ventral hernia, and urged to wear the belt for about two years. She must also be instructed about the avoidance of muscular exertion. Keep the bowels regular, and suspend the marital relation for at least three months.—*Univ. Med. Mag.*

The Treatment of Club Foot by Continuous Leverage.—Henry Ling Taylor, in the *New York Medical Journal*, describes his method of treating equino-varus. His aims are: (1) Preservation of the heel cord as an aid in unfolding the foot. (2) Reduction of the varus first and then the equinus. (3) Exact prehension of the foot by means of an apparatus not attached to the shoe, and by adhesive plaster applied to the leg. (4) The application of leverage to the inner side of the foot and leg. (5) Thorough mechanical after-treatment. The varus is first to be overcome by applying a wooden or metal strip padded and strapped at the ends to the fore part of the foot and to the leg below the knee, while the ankle is drawn toward this line by a third strap placed a little above that joint. The tendo-Achilles may be divided to let the heel down, or a set screw at the ankle used for the same purpose. A steel shoe is now to be worn day and night. The heel is kept down in the shoe by a piece of webbing fastened to three adhesive straps applied to the leg. The lower end of this webbing is buckled to the inner side of the sole plate just behind the ankle joint. The author states that in most cases under six or eight years of age, and in many older subjects, the deformity can be reduced in a few weeks. The foot is then to be held in its corrected position from one to several years, while the patient goes about independently in his brace, which is concealed by his shoe and stocking. Inversion of the knee may be controlled by an apparatus reaching to the hip, and, if necessary, the addition of a hip band will regulate hip rotation. In spastic conditions tenotomy is positively indicated in addition to mechanical treatment. In calcaneous, ankle flexion is prevented by a stop a stop at the ankle joint of the apparatus, while the weight of the body in standing and walking is transmitted from the anterior end of the sole plate through the apparatus to a broad band passing in front of the head of the tibia.—*Univ. Med. Maga.*

Lawson Tait on the Treatment of Peritonitis.—Years ago I was driven to the determination to discontinue the use of opium by the mouth after abdominal operations, for two reasons; first, its action on the intestines is most certainly to modify and even suspend vermicular movements; and secondly, it masks the real condition of the patient. One dose of morphine, given under the skin immediately after the operation, is all that my patients ever get, and the bulk of them do not get that.

Regarding the intolerable thirst that follows the opening of the peritoneal cavity, I have come to look upon it not as an indication for the administration of fluids, but rather for withholding them. Ice is one of the things that should be banished absolutely from the sick room. It never acts in any other way than to increase thirst.

Again, if nausea sets in on the third or fourth day, or at any time after, all food (and in that I include water) is absolutely stopped for twelve hours or even longer if necessary. I was driven to this by the uniform experience that all drugs employed for the arrest of vomiting were absolutely futile; that any food given came back only altered by biliary admixture. Further, I was influenced by the perfect certainty that nothing could possibly be digested or absorbed by the stomach so long as bile was being poured into it.

I have therefore a belief that the starvation and withholding of fluid prevents the mechanical stasis of the circulation in the intestinal coats, which appears to me to be the initial stage of the fatal process of peritonitis, and this preventive measure I endeavor to assist by stimulating the peristaltic movement. I have tried a vast number of different kinds of enemata—some suggested by my own thought, and others suggested by ingenious friends—but I have always gone back to soap and turpentine. It is the business of any nurse watching one of my abdominal sections to note every six hours a set of four conditions—the

pulse, the temperature, the occurrence of distension, and the passage of flatus *per anus*. So soon as the latter is freely and naturally established our anxiety ends, though our watchfulness is unremitting. The want of such passage for twenty-four hours after an operation, especially if accompanied by the slightest suspicion of distension, is dealt with without fail by the nurse herself, on her own responsibility, by the administration of a turpentine enema. If the turpentine does not answer, the nurse reports, and a mild saline purgative is ordered—generally a seidlitz powder—and this is repeated every four hours until it acts. If the distension increases, we never rest until we have had the bowels moved, and then our anxiety is nearly always at an end and our efforts rewarded by recovery. But above all things there must be no time lost, and nobody who may be called into consultation by anxious friends must be permitted to write a prescription and try some favorite mixture.

When called into a case of well-established peritonitis I always urge a trial of this treatment, because the stage may not have passed at which it still may be effective, but the chances are that it has. I have never said that the purgative treatment will cure peritonitis, for peritonitis, once it is completely established, is a practically incurable disease, and most uniformly fatal. Of this I am certain, if you subject the patients (not the peritonitis) to the purgative treatment, the number who will go on to incurable peritonitis will be fractional compared to what will be the result if they are left alone or submitted to any other treatment.

The practical outcome of my empirical experience is this, that the purgative treatment of peritonitis or threatening peritonitis, if it be promptly brought to bear on the case, will gain the all-important time, which will eventually turn the scale in favor of the patient.—*British Medical Journal.*

PHIMOSIS AND CIRCUMCISION.—In a paper read at the meeting of the Colorado State Medical Society, June 22, 1892, Dr. Horace G. Wetherill draws the following conclusions:

1. That each male child should be examined at birth for obstructive phimosis when we examine for imperforate anus.

2. That the prepuce should be retracted fully, and all adhesions to the glans broken up, all smegma be removed, and the nurse be instructed to retract, wash and annoint the parts daily for two weeks, and once each week thereafter.

3. That a long and redundant foreskin, though freely retractable, may be a cause of local and reflex diseases; may occasion, or at least exaggerate, an undue sexual appetite, and so predispose to masturbation, sexual excesses, and ultimately to venereal diseases.

4. That such cases should be circumcised, as should the cases where the foreskin is not retractable.

5. That routine circumcision of all male infants is to be condemned. That the prepuce plays an important part in the human economy, and should not be amputated except for good and sufficient reasons.

6. The unhappy experience of a fatal case cited by the author demonstrates that this little operation may be attended by grave dangers, and should be undertaken with this risk in view, and only after we are assured that the parents' families are not bleeders.

7. That infants may endure a copious hæmorrhage far better than we have heretofore supposed—*University Medical Magazine; The Satellite.*

CRANIECTOMIES FOR CEREBRAL DEVELOPMENT. (*Mal de l' Enf.*,)—First case was of a little girl, four years and two months, unable to sit up alone, indifferent to everything, not seeking to grasp objects within her reach or which were presented to her. First craniectomy was done October 7, 1891, the seat of the operation being the left fronto-pariental suture. Following this, the child began to sit up unaided and to seize objects following a second intervention; in twenty-two days the child has shown an increased intelligence and consciousness of surroundings. At present she begins to stand.

The second case was of a boy of eleven and a half years, excitable, noisy, mischievous, breaking everything which was given him. First operation in December, 1891, by M. Lannulongul. Craniectomy following the left fronto-parietal suture. An improvement followed. The operation was completed by M. Chenieux, in October, 1891, crossing the longitudinal sinus and following the length of the right coronal suture. The child has become susceptible to attentions and capable of education. He is much less excitable. The two cases will have later craniectomies along the left sagittal sutures.—*Arch. of Ped.*

TREATMENT OF INGROWING TOE NAIL.—Dr. J. A. Batton, *Polyclinic*, has the following to say on this subject:

The disease begins at the margin of the nail as an abrasion of the skin caused, perhaps, by pressure from a tight fitting shoe. From this focus of inflammation comes the proliferation of cells and the consequent hypertrophy until the whole side and end of the toe is involved in the inflammatory process and is exceedingly painful and tender.

With a knowledge of the value of continuous pressure in the relief of inflammation, especially when it is superficial; witnessing the effect of Martin's bandage on varicose ulcers of the leg, with their consequent induration, first led me to think of the elastic bandage for the removal of the hypertrophied mass overlying the toe nail.

The method I have used for several years is as follows: Dust over the granulations at the bottom of the sulcus with aristol or iodoform and on top of this put a small piece of lint or cotton.

Take a piece of rubber bandage one-half inch wide and twelve to fourteen inches long and, if it is the inside of the toe that is affected, carry the bandage over the nail toward the inflamed structure. This, as you will observe, will have a tendency to carry the mass away from the nail. Beginning at the extreme end of the toe, carry the bandage back, with such pressure as the patient can comfortably stand, until the whole area of inflammation is included. Fasten it by means of a light gum band or tapes fastened to the end of the bandage.

The patient is then able to wear his shoe and attend to his ordinary duties.

The bandage can be removed at night and reapplied by the patient himself, if desirable, the first thing in the morning.

At the end of a few days you will notice a marked reduction in the size of the toe, and at the end of a short period be able to demonstrate for yourself

whether an "ingrowing toe nail," is in reality, an ingrowing toe nail.

THE CONDITION OF THE URETHRA IN GONORRHŒA.—Dind (*Therap. Monatsh.*), after pointing out the divergence of opinion existing as to whether a gonorrhœa usually involves the posterior portion of the urethra, inclines to the view that the affection nearly always extends thus far, and quotes in support of this view Jadassohn, Eraud, and Le Proviat. He describes the ordinary method of diagnosis, and advocates the following, by which, in eighty-eight cases, he only six times failed to detect the coexistence of a posterior urethritis. The urine having been retained for three to six hours, the anterior urethra is cleansed by irrigation; then the urine is passed and examined for pus, etc., the presence of which is held to confirm the diagnosis of extension to the posterior urethra. Acute cystitis and a weak membranous sphincter, easily yielding to anterior pressure, render this proceeding impracticable. By thus examining his patients frequently, Dind has arrived at the conclusion that posterior urethritis may supervene at any period of the disease. The author is disappointed with the results of salol, both when taken internally and when used as an injection, and Reverdin's treatment with permanganate of potash failed similarly. The negative results after injections he attributes to the condition of the posterior urethra, which cannot thus be reached.—*St. Louis Med. and Surg. Jour.*

EXCISION OF CHANCRE AS A MEANS OF ABORTING SYPHILIS.—Dr. James C. McGuire, *N. Y. Med. Journal*: discusses this operation and advances the following, *Instantaneous* absorption is a physical impossibility. Therefore, for a time the poison of syphilis is confined to the point of inoculation. Granting this proposition, it follows that, if the virus is removed or destroyed within this time, the constitution will not be affected. This is a self-evident proposition, and it only remains for practical experience to show that the poison is localized for an appreciable time. It is my belief that if within a few hours the point of inoculation is thoroughly cauterized, syphilis will many times be prevented. In conclusion, I cannot do better than to quote Dr. L. Brocq, who says (in the *Journal of Cutaneous and Genito-urinary Diseases*, January, 1892): "For us there exists but one legitimate and logical excision of the syphilitic chancre—the one which could be made immediately after the infecting coitus, just as we cauterize with a red-hot iron the bite of a mad animal. We should then have to do with a lesion probably still local if we intervened quickly enough. This brings us back practically to the common precept, 'After a suspected coitus wash with an alcoholic solution of bichloride of mercury and cauterize vigorously your excoriation, if you have any.'"

PUBLIC SYMPHYSEOTOMY AS A STEP IN OPERATIONS ON THE BLADDER.—According to the *Semaine Medicale*, Dr. Aibarran presented to the French Academy of Medicine on January 17th, a man, aged thirty-one years, on whom this procedure had been done as part of an operation for the removal of an epithelioma of the bladder. This patient had undergone an operation for the removal of a vesical tumor in April, 1890, by a suprapubic incision. That growth was pediculate but about a year later it was succeeded by a sessile epithelioma which proved the source of considerable hæmaturia. The growth was situated close to the neck of the bladder and extended on to the left lateral wall. In performing the section it was first necessary to make a X-shaped incision through the superficial tissues in order to get the penis moved to to one side. The symphysis was divided with the knife, followed up by chisel and mallet, and then, by flexion and abduction of the thighs, the pubic bones were separated about two inches. This afforded the room required to exercise a suitable portion of the inferior and left lateral portions of the bladder. The wound in the bladder was closed by a double row of sutures, and a catheter was introduced and left in position. The patient was placed in a Bonnet's splint and kept there seventeen days. An obstruction of the catheter caused a perineal fistula at about the end of the third week; otherwise the patient's convalescence was uneventful. The patient had gained in weight and was able to retain his urine for three hours or longer; he walked without discomfort and had resumed his former employment. There was no longer any perineol fistula, and the scar left by the wound was small. Wickhoff, of Vienna, has lately made known the results of experiments on the cadaver made to test the advantages of symphyseotomy over epicystotomy in operations on the prostate and for the removal of neoplasms. He recommends the operation in such cases as being both easy and safe. He believes it may also be serviceable in certain cases of vesico-vaginal fistula.—*N. Y. Medical Journal.*

Therapeutics.

FOR ANÆMIA.—Dr. S. Solis-Cohn publishes the following among "Favorite Formulas," in the *Polyclinic*:

In several cases of malarial intoxication of long duration, in which anæmia has been marked, and in which after cessation of acute symptoms a course of arsenic has failed to bring about marked improvement, rapid return of corpuscle and hemoglobin to an approximately normal standard has followed the administration of a solution prepared as follows:

Take: Tincture of ferric chloride 2 fluid drachms
Diluted phosphoric acid 3 fluid drachms.
Glycerin 6 fluid drachms.
Solution of hydrogen dioxide (Oakland C. C.) enough to make 3 fluid ounces.

Two teaspoonfuls in 3 ounces of water before meals thrice daily.

This is slightly modified from a formula of B. W. Richardson's. It will be practically stable for the few days during which the 3 ounce mixture lasts. It is useful in chlorosis and anæmias generally.

ERYSIPELAS.—In *L'Union Medicale*, Cheron, in the issue for March 10, 1892, contributes an article upon the treatment of erysipelas, gathering his information from a large number of journals, and thereby presenting the methods of a large number of physicians.

He states that in the *Wiener Klinische Wochenschrift*. No. 29, 1892, Koch recommends the following solution:

℞ Creolin, 1 part.
Iodoform, 4 parts.
Lanolin, 10 parts. M.

This pomade is thoroughly spread over the erysipe-

latous patches and covered with gutta-percha. Both employs the following :

℞ Creolin, 1 part.
Prepared chalk.
Lard, aa 15 parts.
Peppermint oil, a few drops.

This is applied to the inflamed part, and produces a cooling effect, which has very excellent results.

In the hospital at Copenhagen, Ulrich has employed cold compresses, and applications of tar and ichthyol collodion, which is made as follows :

℞ Ichthyol, 5 parts.
Ether, 5 parts.
Collodion (flexile), 10 parts.

He gives at the same time, internally, sulphate of quinine to reduce the temperature.—*N. E. Med. Jour.*

Treatment of Acute Bronchitis.—Simple cases usually recover (Dr. Canfield, *Therap. Gazette*) under the use of a good expectorate mixture, such as—

℞
Ammon. muriat..... ....ʒ ss
Mist. glycyrrhiz, co.....ʒ iv
M. Sig.: Dessertspoonful every three or four hours.

When the secretions are abundant and not easily coughed up, a turpentine emulsion is excellent. For instance:

R.
Ol. terebinth.....ʒij to ʒiij
Muc. acaciæ.....q. s.
Aq. cinnamon.....ʒ i
Aquæ. q. s. ad.....ʒ vj
M. Sig.: Tablespoonful in water every four hours.

Sometimes the cough is of such an irritating character that expectorant measures avail little. Some narcotic must then be used. Codeine has not the disadvantages of morphine, and is efficient. A good combination is:

Codeine sulphat.....grs. viij
Syr. prun. virgin.....ʒ viij
M. Sig.: Tablespoonful in water three or four times per day and at bedtime, if necessary.

Apropos of the Treatment of Diphtheria.—The general opinion is that it is necessary above all things to destroy the baccilli and the streptococci, to combat the toxic effect of their products and to sustain the patient. As to the best means of doing this opinions are divided, especially among the Germans, as will be seen from the following epitome.

Baginsky considers the best treatment to be corrosive sublimate $\frac{1}{3000}$ for gargles, and $\frac{1}{500}$ for local use, with sprays of lactic acid and papapine. Result: Mortality of 40 per cent.

Struebing uses locally solutions of iodophenol tr. iron and sulphur, with gargles of lime water, and cyanide of mercury internally. Later on he uses locally carbolic acid, alcohol and turpentine.

Wilhelmy cauterizes the diseased surfaces with solution of zinc chloride 20 per cent, and uses gargles of lime water with spirits peppermint.

Barbin is of opinion that the most effectual local application consists of sulpho-carbolic acid 20 per cent, applied every hour during the day, less often at night.

Stein extols the method of Burghardt, generous diet, gargles of lime water and insufflations of a mixture of quinine and sulphur.

Janicke and others use methyl violet locally, from 2 to 10 per cent solutions or powders.

Gunz prefers chrome water, containing in the daily supply ⅓ grain bicromate potash.

Ozegowski has used for ten years a mixture of three to five parts each of carbolic acid, citric acid and tinct. iodine in 100 parts of brandy. This is applied to the throat every two or three hours.

Martin employs locally a mixture of carbolic acid one part, camphor one part, glycerine fifty parts, water fifty parts.

Moskowitz & Klein (of Lugos) are satisfied to apply neapolitan (blue) ointment to the cervical region believing that expectant treatment is as good as any other.

Wissing saturates the air of the room with turpentine by evaporating five ounces daily, near the patient.

Lebwartz recommends sozoiodol in solution or powder.

Hagedorn has recourse to the galvano cautery.

It results, therefore, that the local treatment should be antiseptic, but the best antiseptic has yet to be decided on.—*L' Union Medicale, du Canada.*

Tincture of Iron for Burns.—At the earliest possibility after the occurrence, apply the tincture of iron over the surface of the burn with a feather or soft brush, so as to moisten it everywhere. Where the cuticle is not destroyed and removed it should be used full strong; if the cuticle is gone and the surface raw, dilute with water one-half or two-thirds. How prompt the relief from pain is after the application no one can tell save one who has tried it. In scalds and superficial burns the immediate application will not only allay the pain but prevent blistering. There is a characteristic feature connected with burns that deserves consideration, and that is the tendency to too much and too long continued suppuration—to become chronic and to continue indefinitely. Old sores from burns have usually been hard to cure. For the relief of this kind of traumatisms the proper course to pursue is to prepare and use a salve in the following way: Take of vaseline or lard one ounce, of tincture of iron one drachm, more or less, combine the two by rubbing together either in a mortar or in a plate or saucer with a knife or spatula. Spread this salve thinly upon a soft cloth and apply to the entire raw surface; this will soon diminish the flow from the raw surface and cause it to heal rapidly.—E. F. Starr, *Atlanta M. & S. Journal.*

Bocanina.—This is the name given to a new analgestic discovered in Mexico, and which is said to possess properties equal to cocaine and superior to chloroform. It was used with success in an important operation.

To Remove the Odor of Iodoform from the Hands.—Dr. W. Washburn, of New York, writes to the *Medical Summary:* Ether and chloroform are both solvents of iodoform, and if the hands are washed with just a trifle, after washing with soap and water, the odor will be missing. The hands have a peculiarly clean feeling after using chloroform, dry instantly, and require no further washing, being in a thoroughly aseptic condition. As nearly every physician carries chloroform or ether in his satchel, and as turpentine would be an additional burden, there is

this also in favor of these drugs; they are always at hand.

Dr. Shlapoberski has found the caustic action of nitrate of silver in contact with iodoform, which it decomposes with a hissing noise, very efficacious in the treatment of lupus. In an obstinate case he scraped away all the large nodules and applied nitrate of silver, afterward covering the parts with collodion containing 10 per cent of iodoform. The treatment was renewed daily. In three months there was a decided improvement, and in seven months the parts were entirely healed. There has since been no recurrence, though more than four years have elapsed. —*London Lancet.*

Strophanthus in Pruritus.—Azúa (*Rev. de Med. y Cir. Pract.*) has found tincture of strophanthus useful in pruritus due to stasis of the circulation in the papillary layer of the skin, as observed in some cases of cardio-pulmonary disease. He tried it in seven cases of this kind, and in one of itching caused by jaundice. In the latter the treatment had no effect whatever, but in the other cases the pruritus speedily ceased under the administration of strophanthus. Twelve drops of the tincture were given in two doses every day for seven or eight days. As illustrating the effect of the treatment a case is related in which the patient, a man aged seventy, the subject of emphysema and dilated heart, had suffered for many months from troublesome pruritus. After a week's administration of strophanthus the itching entirely ceased. The results in the other six cases were equally satisfactory. The effect of the strophanthus was so striking that Azúa seems inclined to think that the drug may have some specific action on the nerve endings, which may explain its effect in such cases.—*St. Louis Med. and Surg. Jour.*

Diuretic and Purgative Wine.—Dr. Joseph Jones sends the following to the *Times and Register:*

In dropsy and general anascarca arising from organic lesions of the heart, and in Bright's disease of the kidneys, we have employed with benefit, the following diuretic and purgative wine:

℞—Fluid extract of jalap.....f ʒ iij
Fluid extract of squills.....f ʒ iij
Fluid extract of jaborandi.....f ʒ j
Fluid extract of digitalis.....*m* xxx
Nitrate of potash..... ʒ iv
Angelica wine.....O. ij
M. f. s. a.
Dose.—One tablespoonful every three hours, until ordered to be increased.

This combination has in my hands acted as an efficient diuretic, reducing the greatly distended patient to the normal proportions. The angelica wine is pleasant and supporting menstrunstruum for the diuretics and purgatives.

Of course, I have employed many other diuretics and purgatives in the treatment of the various forms of dropsy, and at the present time desire simply to commend the above formula to the attention of my fellow practitioners of medicine, whose experience will be read with interest.

Diseases of Children.

Retro-Pharyngeal Abscess in a Child; Tracheotomy, Incision, Recovery.—(*Brit. Med. Jour.*)—The patient was one year and seven months old. The child was admitted to the hospital with severe dyspnœa, due to a retro-pharyngeal abscess, and tracheotomy was done at once to relieve this symptom. The next day, July 19, 1892, the abscess was opened under chloroform, by Professor Chiene's method. An incision was made behind the left sterno-mastoid an inch and a half in length, extending downward from a little below the apex of the mastoid process. Several enlarged glands presented, and one or two were removed; the tissues were much matted together by inflammatory exudation. The posterior border of the sterno-mastoid was drawn forward until the transverse processes of the second and third cervical vertebræ could be distinguished. By palpation through the mouth, that portion of the abscess most accessible through the wound was determined and the abscess opened by puncturing with a pair of sinus forceps, several drachms of creamy pus being evacuated. There was no bare bone and no evidence of vertebral disease. The wound, after inserting a drainage tube, was stitched up. The tracheotomy tube was removed on the fourth day. The child made a good recovery, and was discharged quite well on August 5, seventeen days after the operation.

The advantages claimed for this method of operating are: 1. The patient runs no risk from the entrance of pus, often fœtid, into the air passages, and 2. The duration of the case is shorter, and the after-treatment simpler, while the operation is not difficult and ought not to be dangerous.—*Arch. of Ped.*

A New Treatment for Pertussis.—In the *Times and Register*, Sidney B. Straley reports the results of the use of thymus serpyllum in pertussis. He used a tincture made from the green drug. His conclusions are:

1. Thymus serpyllum is a specific for pertussis.
2. It acts in any stage of the disease.
3. It also is a nerve sedative and gastric stimulant.
4. It is necessary to use the green plant.
5. It is perfectly harmless in doses as large as a teaspoonful of the tincture for a child of eight years.
6. The action is fully established in twenty-four hours and completed in five days.
7. Lastly: indications are that there will be no recurrence subsequently, at least not more often than in cases which run the full course.

Creasote in the Scrofula of Children.—Dr. J. Sommerbrot, of Breslau, has obtained excellent results in the treatment of scrofula by means of creasote in *high doses*, either in the pure state (in drops which are taken in milk or wine), or mixed with cod liver oil (in capsules). In children less than seven years old the treatment is begun with three drops of creasote a day, gradually increased to eight and even twelve drops. In children over seven years old it is easy to attain in the course of seven or eight days a daily dose of fifteen grains. It is seldom necessary to exceed the latter dose, but it can be done without inconvenience if required.—*N. Y. Medical Abstract.*

Bacteriological Researches on the Cadavers of Very Young and of Newly Born Infants.—(*Mal. del' Enf.*, Paris, 1892, x., 301.)—These investigations were made with the primary object of ascertaining if the necessary legal delay of twenty-four hours in making an autopsy vitiated any bacteriological research. Autopsies were made in sixteen cases. Examinations were made of the blood from the heart,

the pericardial fluid, and, three times, the cerebro-spinal fluid. The organs examined were the fluids from the spleen, the liver, the bronchial glands and the mesenteric glands, and in one instance the lung. The autopsies were all in the winter and early spring. The author's conclusion is that the legal delay of twenty-four hours, or even thirty-six to forty hours, does not invalidate conclusions to be drawn from bacteriological investigations.—*Arch. of Ped.*

CONGENITAL CYANOSIS, *Intern. Med. Mag.*—The boy, who is now nine years old, seemed to be a perfectly healthy baby at birth. When fifteen days old general cyanosis suddenly appeared and lasted for an hour. The blue color did not again appear until the child was six months old; but it has remained more or less blue ever since. When he gets excited he turns very blue and gets short of breath. In cold weather it is much worse than in warm weather. It is difficult to keep him warm and he takes cold very easily. He has had five attacks of hæmoptysis. For several days before each attack of hæmoptysis, there were distinct choreic movements.

The cardiac sounds are abnormal. There is marked accentuation of the aortic element of the second sound, connected with greatly increased aortic tension. There is also a partial reduplication of the second sound. All the sounds are blurred, as though the two sides of the heart did not contract synchronously. There is however, no distinct blowing murmur constantly heard. Occasionally a murmur difficult to time is heard quite plainly at the base of the heart and about mid-sternum. It is not at all propigated into the aorta and great vessels. It would seem to be produced either at the tricuspid orifice or at the foramen ovale.

This child is a hopeful case. He is growing and the circulation is fairly maintained. The treatment will be directed solely to the protection of the child by hygienic measures from the risks of intercurrent disease, and detailed directions will be given with reference to dress, rest, exercise, etc.—*Arch. of Ped.*

INCUBATION PERIOD OF CHICKEN-POX—*Brit. Med. Journ.* On November 18th, Mrs. M., residing at Hampstead, accompanied by her little boy, visited a married sister at Streatham. They stayed at Mrs. O.'s house about three hours. Soon after they left Mrs. O. found that one of her children had red pimples on the body. The doctor who saw the child next day discovered that she was suffering from chicken-pox. Mrs. M.'s child was taken ill with the disease on December 2d, and the rash appeared on December 3d.—*Arch. of Ped.*

EFFECT OF PURGATIVES ON SUCKLINGS.—In the *Practitioner*, for March, Gow contributes some observations on the effect on sucklings of purgatives given to the mother. The drugs were given for a week, and pains taken to exclude accidental causes of fallacy. Senna, in compound licorice power and in confection, was given to eleven cases, with no effect on the children, except that one was "less costive."

Ten cases were treated with aloes, Barbadoes, two and one-half to five grains daily. In eight, there was no effect; in one the child became more costive, and in one, the bowels acted twice a day, instead of once as previously.

Cascara sagrada was given to ten cases; or which eight were unaffected, one less and one more costive.

Eleven cases were treated with sulphate of magnesia. In five the children's bowels were unaffected, in five they were looser, and in one more costive.

There was no relation between the action on the mother and that on the child, except with the magnesia, and here, in four cases, free action on the mother coincided with the action on the child; while in the other case the mother was affected and the child was unaffected.

TREATMENT OF ROUND WORMS.—Dr. P. Nicholson (*"Med and Surg. Rep."*) commends the following: Give santonine every day for a week only, for fear of poisoning the child. Every evening on retiring introduce into the rectum a suppository of the following composition:

℞ Ext. quassia..... gr. j–ij¼
Cocoa-butter..... q.s.
Make ten such suppositories.

Apply morning and evening a little salve containing a small per cent of calomel or the nitrate of mercury, together with some extract of quassia. Give from time to time the following rectal injection:

℞ Menthol.....gr. j
Olive oil..... ʒj
Sufficient for one injection.

Cut the child's finger nails short and now and then plunge into an infusion of quassia to prevent anto-infection from scratching his anus and swallowing the ova. Finally, combat the constipation with calomel. *Med. Standard.*

Obstetrics.

PUERPERAL SEPSIS—ITS PREVENTION AND CURE.—Dr. William Warren Potter, *Annals of Gyn. & Pæd.*, concludes an article on this subject with the following summary:

1. Obstetric engagements once accepted should be faithfully fulfilled, no matter how awkwardly they fit. Apply the same rule of cleanliness to rich and poor alike. Decline service when this cannot be done. Human life is too precious to jeopardize it by slipshod, half-hearted or indifferent service.

2. The physician should be a model of cleanliness in body and clothing, and should insist upon the observance of similar conditions by all persons in and about the lying-in chamber.

3. The delivery room, whether in hovel or palace, court, alley or avenue, should be simple in its furniture and hangings, and be cleaned with soap, water and whitewash (if possible to use the latter) immediately before occupancy by the puerpera.

4. The delivery bed should consist of a new tick filled with sweet and clean straw, covered with a blanket, impervious dressing and a folded sheet, with other clean covering to be allowed, according to season. Exceptions to this simple bed should be as few as possible, and in no event should a bed be substituted that has been used by the sick, or that is not beyond even a suspicion of infection.

5. The patient should be specially prepared for delivery by baths and enemata, vaginal douches and clean clothing; and labor should be conducted on the lines of absolute cleanliness, with few digital examinations, and a complete delivery of the secudines.

6. Lesions of the genital tract should receive careful attention; rents of the perinæum should be re-

paired, and so, too, in some instances should tears of the cervix.

7. Antiseptic solutions containing a germicide should be used for cleaning the hands and instruments of the operator. Intra-uterine irrigation with sterilized water should be carefully employed after operative midwifery, either manual or instrumental.

8 Finally, if sepsis proceed to suppuration and abscess, the abdomen should be opened, pus cavities emptied, irrigation used and drainage established. If the uterus and adnexa become thoroughly infected they should be extirpated.

DIGITAL DILATATION OF THE PREGNANT UTERUS.—Dr. Ernest Copeland (*Annals of Gyn. and Pæd.*, describes his method of rapidly emptying of the uterus at term:

After taking all proper precautions to render the parts aseptic the patient is put completely under the influence of an anæsthetic; she is then placed in the dorsal position and the index finger of the operator's right hand is inserted in the cervix. When the cervix is sufficiently opened to admit two fingers, the index finger of the left hand is also introduced, and the uterus drawn down.

It is often of undoubted benefit to have pressure from above, if you have an extra assistant. The fingers are now rotated from left to right and right to left, the finger of each hand completing half a circle, bringing uniform pressure to bear successively on each portion of the cervix; as the cervix dilates, other fingers are introduced until three fingers of each hand are used. Of course, the stronger the fingers the more rapid will be the dilatation.

I would emphasize that this is not simply a stretching process, but uniform distribution of force successively to each portion of the cervix.

My experience is that there is no more danger of lacerating the tissue than in a normal labor, where one must resort to instruments or turning. When the uterus is sufficiently dilated the case is conducted as an ordinary labor. I have practiced this method of dilating for several years, and have yet to find a case that could not be readily dilated.

BREECH PRESENTATION.—Prof. Pinard, the eminent French obstetrican, calls attention to the fact that in breech presentations pressure on the fundus of the uterus gives rise to severe pain at the spot where cephalic ballottement is perceived (*Hosp. Gaz*). The pain may even occur independently of pressure, and it is attributed to irregular distention of the upper part of the uterus by the fetal head. Under these circumstances, when the uterine walls are greatly distended, as in hydramnios, the pain may be slight or altogether absent, the head not being in contact with the fundus. This characteristic symptom is reported to have been present in three-fourths of the cases of breech presentation, and when present it is absolutely pathognomonic.—*Pract. Monthly.*

SUBCUTANEOUS CHLORAL INJECTIONS IN PUERPERAL ECLAMPSIA. Deshages of Orleans (*Abeille Medicin*, February 8, 1882,) considers the subcutaneous injection of chloral a valuable method of its administration in puerperal eclampsia, where it is impossible to administer it by the mouth and there is a rectal intolerance. From his experience in seven different cases, Deshages believes it to be the safest working method of administering chloral. In all cases an initial dose of from 7½ to 15 grains sufficed at once to quiet the patient and to lengthen the period between the seizures. The total quantity used was usually from 45 grains to 1 drachm, given either in three doses at intervals of eight to ten hours, or following a large initial dose, hourly, 1½ to 3 grains. The largest quantity used was 75 grains. The effect of the large initial dose differs in individuals, according to the depth of the uremic intoxication, the condition of the os, the pains, to the nearness of the delivery. The injections are only to be used in comatose conditions, on account of the severe pains accompanying them, unless morphia or cocaine are added. The strength of the solution should not be greater than 1.10, and the syringeful should be very slowly injected.

Deshages has also used this method in the eclampsias of nonpuerperal origin with good results.—*University Medical Magazine.*

Gynæcology.

ARTIFICIAL PREGNANCY.—In *Leonard's Ill. Med. Journal*, Dr. L. W. Roesin reports the case of a woman, married for ten years, who suffered from dysmenorrhœa and sterility. Treatment had been futile. Examination showed pelvic organs to be normal. She gave a history of strong uterine contractions during coition. A wire uterine dilator was introduced into the uterine canal with instructions to allow it to remain eight days. The menstrual period was due in ten days.

Coition was ordered every fourth night and one hour previously a full dose of morphine was to be taken. On the tenth day after beginning this treatment she was attacked with severe pains. Examination showed the wire dilator enveloped in many folds of a thin membrane lying in the vagina. The flow was not excessive and soon ceased without treatment. Two days after cessation of her menses she was examined a few minutes after intercourse with her husband. A quantity of spermatic fluid was present around the neck of the uterus. A long nozzled syringe was introduced, this fluid drawn into it, the nozzle of the syringe inserted into the uterus and its contents slowly emptied into the uterine cavity. No unpleasant sensations resulted. The patient missed her next menstrual period; she had become pregnant, and went on to a normal delivery at full term. The doctor did not tell either the husband or wife of the artificial assistance used in securing the pregnancy.

TETANUS AFTER OPERATION FOR LACERATED PERINEUM.—In a paper read at the meeting of the American Society of Obstetricians and Gynecologists, Dr. Edwin Walker reported a case of the above nature. It was one in which "Emmet's operation" had been done, silkworm gut being used and the usual aseptic precautions taken. On the fourth day the temperature rose to 103° with no indications in the wound of trouble there, so the rise in temperature was attributed to malaria. Quinine lowered the temperature, and on the seventh day the thermometer registered 99⅘°, with a pulse of 66. Then she complained of stiffness of the muscles of the face and neck. On the eighth day the case was marked, and in the morning of the ninth day convulsions set in and the woman died that night. Morphia was used to quiet

the patient. The probable cause of tetanus was charged to sepsis, and the point of infection to the finger, which was placed in the rectum during the placing of the sutures, infecting the wound later.—*Annals of Gyn. and Pæd.*

PRURITIS VULVÆ.—In a clinical lecture last year Olshausen divided pruritus of the vulva into two main groups: 1. Where it is symptomatic, as in discharges, diabetes mellitus, etc. 2. Where it is a definite entity, when one looks upon it as a neurosis. Seeligmann calls in question whether these groups include all the cases met with. He points out that discharges from the genitals, both infectious and simple, are very frequent in women; and mentions the fact that out of thirty-seven case of diabetes mellitus in women, only four suffered from this troublesome affection. The notion of a neurosis, the expression of which is confined to the small branch of the pudendal plexus supplying the outer skin of the vulva and the mucous membrane of the vestibulum, in an individual otherwise free from all nervous phenomena, seems to him far-fetched. He states his belief that in almost all cases of pruritus of the vulva there is a micro-parasitic local infection. Microörganisms have been already found in the so-called vulvitis diabetica; and the remedies empirically used in the treatment of the pruritus, such as carbolic acid, sublimate, salicylic acid, etc., are potent in the destruction of low organic life. In a case studied bacteriologically, Seeligmann isolated the bacterium ureæ. The patient, a healthy married woman of forty-one years, suffered severely from pruritus for three years, for which treatment seemed almost hopeless. There was no discharge, but the orifice of the urethra looked reddened and projecting forward. Further examination revealed a tumor, growing from the urethra and going as far back as the entrance into the bladder, and the unconscious passage of minute quantities of urine. Removal of the growth caused cessation of the pruritus, and the obvious explanation was that the dribbling away of urine allowed the bacteria developing in the urine to settle and propagate there. Seeligmann sums up his ideas in the matter of treatment as follows: 1. To seek for and exclude all possible sources of a micro-parasitic infection (latent diabetes mellitus in the husband, cleansing of clothing, water closets, etc. 2. To remove the tendency of the outer skin of the vulva to become the seat of organisms; and, 3. To destroy them when present.—*Berlin klin. Wochenschr. Practitioner.*

ELECTRICITY AND UTERINE FIBROIDS.—Dr. J. M. Baldy, *Annals of Gyn. and Pæd.*, relates the following and incidentally expresses his opinion of electrical treatments:

A few days ago I removed a uterus with a fibroid tumor that presents some points of interest. The patient had been treated by Dr. Massey with electricity for a year and a half or two years. The patient was finally placed in bed for three or four months. She got out of bed to come to me for an opinion, and was confined to her bed for another month before she could come to the hospital for operation. I made a complete removal, and she is now convalescent. There is one small nodule which looks slightly suspicious. It is interesting from the point of view that it had been treated by electricity so long by an expert, and only ended in coming for this treatment, which should have been applied in the first place. It is a fair specimen of what is happening to all the fibroids treated by electricity in this city. Unfortunately, some of them do not find their way to a surgeon before they have suppurated. I have made up my mind to refuse to operate on any more fibroids which suppurate during the treatment by electricity. This woman came soon enough to be saved. Her operation is ten days old, and she is perfectly safe and convalescent. I amputated at the neck and dropped the pedicle, stitching the peritonæum over the stomach.

PERINEORRHAPHY, MYOMECTOMY AND OVARIOTOMY DURING PREGNANCY.—The November issue of the *British Gynecological Journal* contains abstracts of articles illustrating the tolerance of the pregnant uterus to operative interference upon or near to it.

Weil (*Prager medinische Wochenschrift*, 1892, No. 11) reports an operation upon a perineum which was lacerated completely, and involved the sphincter and recto-vaginal septum. The patient was in the fifth month of pregnancy, but no unfavorable action was observed upon the course of gestation, and a living child was delivered at term.

Weil considers it far better to operate upon such cases while pregnant than to allow the patient to suffer from the effects of a lacerated perineum. The lack of perineal support may induce abortion, or a persistent diarrhœa may soon cause impairment of the patient's strength.

Under the heading of myomectomy, Strauch (*St. Petersburger medicinische Wochenschrift*, 1892, No. 10) records an operation for subserous, pedunculated fibroid in a patient who was advanced four months in pregnancy. The pedicle was ligated, tumor removed, and the peritoneum stitched over the stump. The operation was short, the recovery uninterrupted, and the woman was delivered of a live child at the end of nine months.

Christian Fenger (*Journal of Gynecology*) operated upon a patient four months pregnant for the removal of a dermoid cyst. The woman went on to term, and was delivered of a six-pound child. It is important to remove these growths, for they increase rapidly in size during pregnancy, and complicate delivery if located in the minor pelvis, or the gravid uterus may cause torsion of the pedicle, circulatory disturbance, gangrene or perforation of the cyst. Fenger's statistics show the danger of these cysts when complicating pregnancy: In 350 deliveries, 113 maternal and 215 fœtal deaths occurred. Puncturing the cyst has only a temporary advantage, and has some serious disadvantages, viz., the cyst may be malignant and poison the patient; there is a liability of puncturing the uterus, and the mortality of puncture of such cases in general is 19 per cent. Ovariotomy gives the best results.—*University Med. Magazine.*

ALEXANDER'S OPERATION MODIFIED.—Chalot (*Nouv. Arch. d' Obstét. et de Gynec.*,) shortens the round ligaments in a more complete manner than has hitherto been practiced. The inguinal canal is laid almost completely open, so that without difficulty the entire thickness of the round ligament is detected even in the fattest women. Each ligament is dissected deeply up to and beyond the internal ring, even into the peritoneal cavity. The uterus is not held in its reduced or normal position by an assis-

tant, but reduction is performed by firm traction on the two round ligaments. Each ligament is fixed by suture along the whole of its course in the inguinal canal. No pessary is applied after the operation. Chalot has successfully operated in six cases of painful reducible retroflexion. In the earliest case, performed fourteen months before publication, the uterus remained in its normal position. Chalot maintains that his operation is certain of its aim, and more complete than its prototype established by Alexander. Owing to more thorough exposute of the parts it is simpler and easier.—*British Medical Journal.*

Ophthalmology.

INDICATIONS FOR THE ENUCLEATION OF AN EYE.—Dr Edward Jackson, *Philadelphia Polyclinic*, April 15' 1893, concludes an article on this subject with the following summary:

1. The presence in the eye of a milignant new growth, as glioma, sarcoma, or tuberculosis. This indication is imperative no matter how much vision the eye retains.

2. The presence in the eye of a foreign body, with iridocyclitis. If the injury be recent and the inflammatory process still active, and the patient cannot remain under observation, an eye with anything less than thoroughly useful vision should be sacrificed.

3. The presence of a foreign body in a blind eye.

4. Blindness with diminished tension of the eyeball, following perforation either by traumatism or corneal ulcer most urgent after traumatic perforation of the exposed portion of the sclera.

5. Blindness the result of irido-chloroiditis without perforation of the eyeball, if the patient cannot remain under observation.

6. Sympathetic inflammation, provided the exciting eye does not possess vision sufficiently good to be weighed against the chances of the sympathizing eye.

7. The actual presence of sympathetic irritation; not the risk of it, unless the patient is likely to be out of reach of surgical aid.

8. Persistent pain in a blind eye, sufficient to annoy its possessor or tempt him to the use of analgesic drugs.

9. Serious disfigurement of a blind eye, even if free from pain or risk of causing sympathetic diseases.

Toxicology.

DEATHS UNDER ANÆSTHETICS.—Gurlt reported to the last surgical congress at Berlin, the following statistics of deaths under anæsthetics. They are made up from the observations of 62 operators, who anæsthetized 109,196 persons with 39 fatal results, showing 1 death to 2,800 narcoses. The following were the anæsthetics used:

Chloroform, 94,123 narcoses, 36 deaths.

Ether, 9,431 narcoses, no deaths.

Ether and chloroform, 2,891 narcoses, 1 death.

Ether and alcohol, 1,381 narcoses, no deaths.

Bromoform with ethyl bromide, 2,151 narcoses, 1 death.

Penthal, 210 narcoses, 1 death.

In 2,913 cases the narcosis lasted over an hour; in an operation for utero-vaginal fistula, 4½ hours; in a case of tetanus, 9 hours. In 25 cases, of which post-mortem examinations were made, cardiac diseases were found. The author urges careful examination of the heart before administering chloroform. —*Cond. Extracts.*

Rhinology.

A PLEA FOR CLEANLINESS IN THE TREATMENT OF NASO-PHARYNGEAL CATARRH.—This is the title of a paper by Dr. Edward J. Bermingham, Surgeon-in-Chief to the New York Throat and Nose Infirmary, in which he lays stress upon the importance of cleansing the nasal cavities from one to three times daily after an existing stenosis has been relieved, and during the employment of topical medication by the surgeon. If the parts are not cleansed, the medication does not reach the diseased mucous membrane, and treatment will be disappointing. Proper cleansing with an alkaline, antiseptic, nonirritating, and deodorizing solution will alone cure 50 per cent of cases of simple hypertrophic catarrh and will benefit atrophic cases. The writer gives preference to a 25 per cent solution of glycothymoline as a cleansing fluid. He condemns the old-time douche and all those where any force is used, and advises that the fluid be introduced, through a small glass douche devised by him, which allows the fluid to gravitate slowly to the naso-pharynx. Here it should be kept in contact with the parts for a minute or two before the nose and throat are cleared.—*N. Y. Med. Jour.*

PUBLISHER'S DEPARTMENT.

IN THE St. Louis *Medical Era*, Dr. C. A. Jennings reports a case of typhoid fever in which after failing to secure benefit from the ordinary method of treatment he resorted to katharmon. Half drachm doses were administered, the temperature diminished, the other symptoms were improved and convalesance speedily established.

AN EPIGRAM CONFIRMED.—Dr. W. E. Anthony, of Providence, R. I., writes as follows:

"When I was a medical student, in 1865, I remember hearing Dr. Oliver Wendell Holmes, then Professor of Anatomy at Harvard College, say to his class: When you begin practice you will have twenty remedies for one disease, but after twenty years you will have twenty diseases for one remedy.' That prediction seems to be fulfilled in the use of antikamnia, which seems to meet so many indications."

BOOK REVIEWS.

A BOOK OF OUTDOORS.—"Outdoors" is the title of a refreshing little book which is a pleasure to read. The covers are in ten water colors, and inside are articles on Lawn Tennis, by F. A. Kellogg; Yachting, by George A. Stewart, successor to Edwin Burgess; Cycling, by Julian Hawthorne; Football, by Walter Camp; Baseball, by J. C. Morse; Horsemanship, by H. C. Merwin; Rowing, by Benjamin Garno; Canoeing, by C. Bowyer Vaux; a compilation of authoritative articles on healthful outdoor pleasures, illustrated by Copeland, Beals, Gallagher, Young, and Shute. This

book, published by the Pope Mfg. Co., of Boston, for the benefit of the Columbia Bicycle, contains articles without any advertising in them. Sent by mail to anybody for five two cent stamps.

Pamphlets and Reprints.

"Annual Address before the State Board of Health of Pennsylvania." By Samuel G. Dixon, M. D. E. K. Meyers, State Printer, Harrisburg, Pa. 1893.

"Hydrogen Dioxide." By Samuel S. Wallain, A. M., M. D .Reprinted from the *New York Medical Journal*, November 26th, 1893.

"Optometry." Lecture to the Class of the University Medical College, of Kansas City. By Flavel B. Tiffany, M. D. Reprint from *St. Louis Medical and Surgical Journal*, January, 1893.

"Methods of Precision in the Investigation of Disorders of Digestion." By J. H. Kellogg, M. D., Modern Medicine Pub. Co., Battle Creek, Mich.

"Some Points in Reference to the Inflammation of Cartilage." Address of the President, Dr. Benjamin Lee, American Orthopœdic Association.

"Ability of the State to Prevent an Epidemic of Cholera." By Benjamin Lee, M. D. Reprinted from the *Medical News*, Sept. 17th, 1892.

"Reports of the Board of Trustees and Superintendent of the Arkansas State Lunatic Asylum," for the biennial period ending November 30th, 1892. The Press Printing Co., Little Rock, Ark.

"Skin Grafting Upon the Cranium," By Frederick C. Schaeffer, M. D. Reprinted from the Chicago *Medical Recorder*, February, 1893.

"Brain Surgery—Injury Received Five Years Ago, Followed Three Years Later by Convulsions and Paralysis—Bloodclot Found Under the Dura Mater and Removed—Patient Improving." By F. C. Shaeffer, M. D. Reprinted from the Chicago *Clinical Review*, March, 1893.

"Vertebral Surgery, with Reports of Three Cases, and a New Method of Operating in the Dorsal Region." By F. C. Schaeffer, M. D. Reprinted from the Transactions of the Illinois State Medical Society, 1891.

Announcements.

Manifesto of the Section on Otology Pan-American Medical Congress.

Honorary Presidents.—Drs. Adolph Alt, St. Louis, Mo. ; Albert H. Buck, New York; Gorham Bacon, New York; Wm. Cheatham, Louisville, Ky.; Francisco de P. Chacon, City of Mexico; Sebastian Cuervoy Serrano Sancti Spiritu, Cuba; J. C. Connel, Toronto, Canada; Stephen Dodge, Halifax, Nova Scotia; J. B. Eaton, Portland, Oregon; A. A. Foncher, Montreal; John F. Fulton. St. Paul; J. Wilford Good, Winnipeg, Manitoba ; Francis B. Loring, Washington, D. C.; Henry D. Noyes, New York; Arturo Costa Pruneda, Santiago, Chili; Charles Inslee Pardee, New York; G. Sterling Ryerson, Toronto, Canada; D. B. St. John Roosa, New York; W. H. Sanders, Mobile, Ala; Belisario Soca, Lima, Peru; G. C. Savage, Nashville, Tenn.; J. J. B. Vermyne, New Bedford, Mass.

Executive President.—Dr. C. M. Hobby, Iowa City, Iowa.

Secretaries.—Drs. Max Thorner (English Speaking), Cincinnati, O.; H. McHatton (Spanish Speaking), Macon, Ga.; Fernando Perez, Buenos Ayres, Argentine Republic: Ernesto Mazize, La Paz, Bolivia; Theodoro Peckolt, Rio de Janeiro, U. S. of Brazil; J. H. Wishart, Toronto, Canada; Cárlos Desvernine, Havana, Cuba; Cárlos Esguerra, Bogota, Republic of Colombia; Demetrio Orantes, Guatemala City, Guatemala; H. G. McGrew, Honolulu, Hawaii; Antonio Peñafiel, City of Mexico, Mexico; Dr. Montenegro, Leon, Nicaragua; N. Surh, Montevideo, Uruguay; Focion F. Cordero, Merida, Venezuela.

Advisory Council.—Drs. F. N. Lewis, New York; M. D. Jones, St. Louis, Mo.; J. H. Thompson, Kansas City, Mo.; Robert Tilley, Chicago, Ill,; Thomas E. Murrell, Little Rock, Ark.; N. J. Hepburn, New York; Harold Gifford, Omaha, Neb.; H. C. Hawley, Sioux Falls, South Dakota; Edward M. Whitney, New Bedford, Mass.; T. J. Tyner, Austin, Texas.

The Section of Otology has been rendered necessary by the fact, that while the treatment of diseases of the ear has in the past been mainly in the hands of ophthalmologists, the recent advances in the study of diseases of the nose and pharynx has necessarily divided the practical work of treatment of the diseases of the ear. So that at present we find these diseases considered by both ophthalmic and rhinologic surgeons. It is hoped that in this section surgeons of both classes may meet, and to this end the effort will be made to secure hours not conflicting with either of the other sections.

Communications in reference to papers should be addressed to the English Speaking Secretary, Dr. Max Thorner, 141 Garfield Place, Cincinnati, O., suggestions as to work and exhibition of instruments to the Executive President, Dr. C. M. Hobby, Iowa City, Iowa.

Meeting of the Illinois State Medical Society.—The forty-third annual meeting of the Illinois State Medical Society will be held in Chicago, in the Methodist church block, corner Washington and Clark Sts., on the 16, 17 and 18 of May, 1893. The meeting will be called to order promptly at 9 o'clock A. M., Tuesday.

To avoid the usual delay and confusion incident to registration and paying dues during the first half day, the officers will endeavor to have registration completed by mail, in advance. All members are respectfully urged to coöperate by filling out and returning their registration blanks with the dues for the year, to the Treasurer.

The executive committee has decided, subject to change, to have four full half-day sessions, and one evening session, leaving Wednesday afternoon free, and hoping to adjourn finally about noon Thursday.

A detailed program will be issued and mailed to members before the meeting.

The committee of arrangements hope to secure the usual reduction in railroad fare.

Chicago, Ill., April 12, 1893.

D. W. Graham, Secretary.

Miscellaneous.

Dr. Haffkine's Scientific Mission to India.—The Secretary of State for India has, at the request of the Russian Ambassador, communicated through the foreign office, addressed a letter to the Governor-General of India, requesting that the Indian govern-

ment "will give Dr. Haffkine every facility for visiting districts, towns, and military stations where cholera may be prevalent, for seeing hospitals where cholera patients may be under treatment, and for inquiring into the causes and circumstances of cholera epidemics." The object of Dr. Haffkine's mission is to make known the method of procuring immunity from cholera attacks by preventive vaccination, which he has worked out on animals in the Pasteur Institute.

[The daily papers announce that Dr. Haffkine claims to have achieved success and demonstrated the value of his process.—EDITOR.]

Dr. J. C. MCMILLAN, *Times & Register* reports the case of a child, two years of age, which drank one ounce each of kerosene oil and turpentine. No treatment was instituted as no symptoms of poisoning appeared and the child suffered no inconvenience.

THE following important changes in spelling have been recommended by the American Association for the Advancement of Science:

Aluminum for aluminium.

Cesium for cæsium.

Columbium for niobium.

Glucinum for beryllium.

Sulfur and sulfates, for sulphur, etc.

The suffix *ic* is used for metals only when contrasted with *ous*.

Ol is used exclusively for alcohols.

Final *e* is dropped from all the *ides* and the *ines*.

In such words as mil'lime"ter, the accent is as given.

Latin prefixes alone are used in derivatives of *valence*.

Arsin, for arseniuretted hydrogen, etc.

Gramme instead of gram. because the latter may be mistaken for grain.

FIGHTING MICE WITH BACILLI.—Prof. Loeffler's bacillary crusade against the field mice of the Thessalian plain has ended in victory. It will be remembered that Prof. Loeffler some time ago discovered a new bacillus, the "bacillus typhi murium," which has the power of producing a certain disease in mice, and in mice alone. A plague of field mice threatening to destroy the harvest, having appeared in Thessaly, he was appealed to by the Greek government, and immediately started for Athens. He began his experiments by treating field mice in the laboratory with injections of his bacillus cultivation, and when these experiments showed his method to be undoubtedly the right one, he started for Thessaly with a staff of Greek doctors. Bread crumbs, saturated with the bacillary substance, was strewn broadcast over certain fields, and as early as a week later the results were visible.—*Physician and Surgeon.*

A MIRACLE CURE EXPLODED.—Archbishop Ireland recently dealt in a novel but most sensible way with a so-called miracle cure which was being exploited at Canton, Minn. The report was that a miraculous image of the Virgin and Child had appeared upon a pane of glass in the window of a church at Canton, and that infirm persons were making pilgrimages to the church. Thereupon the Archbishop gave orders that the matter should be investigated by a scientific expert whom he appointed. When the result of the investigation was made known to the Archbishop, a few days ago, he took the action in the case which is required by the laws of the church, and the "miracle window" will not hereafter be seen. The expert found that a fraud had been perpetrated by a photographer of the place who had subjected the pane of glass to a kind of treatment under which, by means of certain apparatus, the images were made to appear upon it. The expert also found that though many infirm pilgrims had been drawn to the place by reports that miraculous cures were performed there, not one of them had been relieved of his infirmity. He furthermore ascertained that a number of conscienceless men in Canton were allied with the photographer, and had mercenary reasons for trying to keep up the delusion.—*N. Y. Med. Rec.*

THE BACTERIOLOGY OF TOBACCO.—Another article of home consumption has been discovered to be under the sway of the all-pervading germs, Suchsland (*Abst. Centralblatt f. Bact. xii:20*) has found that in the process of "sweating," during which many of the aromatic compounds, upon which the flavor of tobacco depends, are formed, the result varies greatly with the kind of bacteria which takes the chief part in this fermentation. German growers of tobacco have tried in vain to improve the quality of their crop by enriching the soil and by introducing foreign sorts. Suchsland, however, by starting the sweating process with pure cultures of germs obtained from the finer foreign tobaccos has been able so to influence the flavor of the German weed as to deceive experienced connoisseurs.—*Omaha Clinic.*

CHILD'S SCALP WOUND DURING DELIVERY.—Dr. J. C. Adams, Lake City, Minn., reports ("N. W. Lancet") the case of a child who had a large flap hanging down toward the right ear. This flap included the thickness of the scalp, and had been torn from the posterior superior part of the right parietal bone. It was an irregular edged, equilateral triangle, measuring about an inch and a quarter at the base and each of the sides. Under the influence of chloroform it was sutured and dressed antiseptically, and united entirely by first intention. The baby was a little restless the second day, but after that did not seem to mind it." As the labor was tedious the parturient requested an elderly neighbor woman to touch her, and find out what was the matter. The latter mistaking a caput succedaneum for the bag of water, pushed her finger through. As the water did not come she made an extensive double tear.—*Medical Standard.*

DEATH WAS JUSTIFIABLE.—Dr. A. P. Fitch sent the following to the *Indiana Med. Journal:*

Within find inclosed a report of a death by a Physio-Med. of this county. What ignorance we have to contend with is only unearthed occasionally. I think it would be good reading. You need not publish names if you think best, but for my part I don't care.

"DEMING, May 23, 1892.

"*Dear Doctor,* I received word to-day that you lost report I sent you of —— ——— death. I now send report:

"J—— S—— died with Typhoid Fever of light form with considerably interic trouble resulting from Chronic diarrhœa of long standing Said diarrhea affected the hemorhoidal Blood vessels and nerves and mesenteric glands, Blood vessels and nerves Pro-

ducing by excessive excitement of the nerves and Blood vessels reflexes action through the sinal cord and aortic regurgitation influenced by the above named diseases produced Inflamation of the entire Base of the Brain as a consecuence causing Inflamation of the Optic nerve resulting in serious Inflamation of the Eyes and the aforesaid diseases caused his death on third of October 1891. —— ——"

INTERNES COOK COUNTY HOSPITAL, CHICAGO.—The annual competitive examination for the positions of interne at this institution, one of the largest hospitals in this country, was recently conducted by thirty members of the regular medical staff.

An examination of the records shows that of the thirty-one competitors, twelve were students of Rush Medical College, nine of the Northwestern University Medical School, (Chicago Medical College), nine of the College of Physicians and Surgeons and one of the N. W. Univ. Women's Medical School.

The eight positions were secured by E. H. Tinen, F. A. McGrew, R. B. Olsen, J. J. Claussen, G. W. Skinner, T. J. Williams, T. P. Findley and T. A. Olney, in the order named.

Representatives of Rush Medical College secured 1st, 2d, 5th, 6th, 8th (five) places; Chicago Medical College, 3d and 7th (two) places; College of Physicians and Surgeons, 4th (one) place.

Interneships in this hospital are among the most valuable positions obtainable in this country and as they are very earnestly competed for by the best students of the different medical schools in that city, the gentlemen securing positions are to be congratulated.

PRENATAL MEASLES.—At a recent meeting of the Obstetrical Society of Edinburgh, reported in the *Edinburgh Med. Jour.* for March, a case was related as having occurred in the practice of Dr. T. B. Darling, in which a woman was attacked with measles when she was at the close of the fifth month of gestation. When the eruption was beginning to fade she gave birth to a fœtus on which spots of the eruption were to be seen, especially on the face, back and legs.

ITEMS.

RED PUS has been oberved by Ferchmin (*Medical News*) in fourteen cases. Almost always found in recent wounds at first dressing. The cause was found to be a bacillus, one-third as long as the diameter of a red blood corpuscle, and about as thick as the pneumonia-coccus of Friedlander. It is colorless, but stains readily by Gram's method; grows best at the temperature of the body, and equally well in diffuse daylight and in darkness. In rabbits, subcutaneous inoculation was followed by fever, loss of appetite, diarrhœa and death.

GYNÆCOLOGY AMONG THE INSANE.—With a reckless haste and publicity not altogether above suspicion of some unworthy political influence, the Pennsylvania State Board of Public Charities condemned the use or surgical methods of relief among the inmates of the female department of the State Asylum at Norristown. The public has thus become more certain than ever of the justice of its horrors of the imagined abuse practiced by the profession upon the defenseless insane and sick. The Board of Trustees of the Asylum, and Dr. Bennett, in reply to the State Board of Charities, have more than met all the charges, and have clearly shown that the question of sanity or insanity has not been considered in the removal of the diseased organs of the six cases complained of. If nothing else is immortal, the bitter suspicion and deep-seated grudge against the medical profession seems destined never to die.—*Medical News.*

WIT AND HUMOR.

"There's naught to make the sufferer grin,
In abscess, boil or tumor,
Although physicians find therein
Considerable humor."

The following epitaph is said to be engraved upon a tombstone in Lincolnshire:

"Here lies the body of Johnny dear,
Snatched away by the diarrhœa."

A CERTAIN CURE.—Young Man (helplessly)—"Doctor, is there any cure for the liquor habit?"

Doctor (thoughtfully)—"Y-e-s, one." "What is it?" Marry a woman bigger than you are."

Stranger.—I notice you called your friend Professor. Is he really a Professor?

Boweryite.—I should say so. Why, dat fellar swollars a sword eighteen inches long, stands on his ear and eats glass out of a church. Professor! Well, I should smile.

HE DIED BY DEGREES.—Mrs. Mulcahey.—"Shure, docther, and is it thrue that little Jimmy O'Toole bit yoore termomty in two and swallowed the mercury?

Doctor.—Yes, my dear madam, it is; and the boy is dead."

Mrs. M. —Shure, docther, an' it were a cold day for Jimmie, poor bye, whin the mercury went down."

Doctor.—Yes, madam, he died by degrees.—*Hot Springs Med. Journal.*

Plaintiff's Attorney.—I've an expert who will swear he's insane.

Defendant's Attorney.—I've an expert who will swear he is of sound mind.

Plaintiff's Attorney.—Then let's pair off on experts and save that much money.

"Darling, how have you been to-day?"

"Oh, nervous, debilitated, sick and unhappy."

"Heavens! You've been reading those medicine advertisements again, I'll bet a hat."—*Judge.*

THE DEAD LANGUAGES.—Witticus—"Well, you doctors have to be pretty well versed in the dead languages, don't you."

Medicus—"Oh, no; we leave that to the undertaker."—*Once a week.*

"I want this tooth pulled. I just can't stand this any longer.

"But, my dear sir, I am not a dentist."

"What in thunder are you?"

"I am an oculist. I attend to the eyes, not the teeth."

"Well, that's all right. Go to work. This is an eye tooth that's bothering me."—*Texas Siftings.*

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

VOL. XV. JUNE, 1893. No. 6.

ORIGINAL ARTICLES.

Sexual Crimes Among the Southern Negroes—Scientifically Considered.*

An Open Correspondence between

HUNTER MCGUIRE, M. D., LL.D., of Richmond, Va.,
President American Medical Association, Ex-President Southern Surgical and Gynæcological Association, Etc., and

G. FRANK LYDSTON, M. D., of Chicago, Ill.,
Professor of Genito-Urinary Surgery and Syphilology Chicago College of Physicians and Surgeons, Surgeon to Cook County Hospital, Etc.

RICHMOND, VA., March 11, 1893.

DEAR DR. LYDSTON:—After reading your paper on "Sexual Perversion," I am induced to ask you to give me, if it is possible, some scientific explanation of the sexual perversion in the negro of the present day.

Before the late War between the States, a rape by a negro of a white woman was almost unknown; now the newspapers tell us how common it is. The crime of a negro assaulting a white woman or female child seems to be growing in frequency. Death—certain, swift, and merciless—is the penalty. This is the unwritten law of every community in the South; from it there is no appeal. It is immutable, and is sustained by every living white in the community in which the crime occurs. I am not engaged here in defending this law, although it is easy to do it. I am trying only to give you some facts on which to base your opinion in a purely scientific discussion.

It is not the legal, social, moral, or political aspect of this perverted sexuality in the negro upon which I ask your opinion. The subject has been discussed in these ways, and without any good. I want you, if you will, to investigate it as a scientific physician—one who has devoted much time to this and kindred matters. I do not know, in all this land, one so capable as yourself of making the examination complete, and I sincerely hope the investigation may result in some benefit to the negro race.

In the South the negro is deteriorating morally and physically; and as the American Indian, the native Australian, the native Sandwich Islander, and other inferior races, disappear before the Caucasian, so the negro, in time, will disappear from this continent. It is only a question of time. All history, from the days of early Rome, shows that no inferior race, without amalgamation, can exist for very many years in contact with the dominant white man; it is the frightful "survival of the fittest."

The ingenious Census Bureau tells another story, you may say. Well, the ingenious Census Bureau has, for many years, been telling many stories, and this is, just now, as far as it is worth while to discuss this point.

During the days of slavery, insanity was very uncommon among the negro race. Now, our large asylums are not capacious enough to hold the insane negroes of both sexes.

Before the War, the negroes were fed upon the food which of all others conduced to their health; "hog and hominy" was the main ration, and with this, an abundance of bread, milk and vegetables. Now, their thriftlessness makes them sometimes suffer for a sufficiency of food, and that obtained is not always of a suitable kind. Many of the most improvident have scarcely enough clothes to hide their bodies, and when able to buy, they generally select flashy and thin flimsy garments that poorly protect them from wet and cold. Their clothes are very different now from the thick, warm homespun they formerly wore. We have also intemperance, excess and impure air from overcrowding and want of ventilation, adding their share to the trouble. Mental depression and anxiety are also common. Laughter and music, universal with them before the War, are now rarely heard. There are many and very notable exceptions to the above, of course, but I am describing the negro masses.

In this State, during the period of slavery, "scrofula," as the word was then understood, was a frequent affection among the negroes. It was shown by the swollen glands, by the tumid belly, by certain ophthalmias, and cutaneous eruptions. The negro was called "scrofulous," and considered disfigured, rather than disabled. Pulmonary phthisis and other purely tubercular diseases, while common enough in the mulatto, were comparatively infrequent in the negro. Now, however, scrofula in the negro seems to have terminated in what has been called its "essential element," and tuberculosis is fearfully common. (I use the words in the senses in which they were then employed.) It is difficult to find in a dissecting-room a negro subject free from tubercular deposit. Another disease that I will only mention—syphilis—is frightfully common.

I cannot speak of the negroes who have moved to the North and West. I have no means of definitely knowing their condition.

If, in treating this subject, some other besides a scientific view is necessary for its complete consideration, don't hesitate to use it.

The newspaper men in the North—by no means all, I am glad to say, but in many instances—in reporting some of the crimes of which I am writing, seem to see only the fearful spectacle of a hung, burnt, or shot negro. They seem unable to see the innocent, mutilated, and ruined female victim and her people; but this is another kind of perversion of mind and heart that neither you, I know, nor I care to discuss.

Sincerely your friend,
HUNTER MCGUIRE.

CHICAGO, March 16, 1893.

My Dear Doctor McGuire:—I consider myself highly honored by your letter relative to the sexual peculiarities of the negro. Your eminent position in the profession and your wide range of information make your request for my opinion peculiarly flattering. I fear, however, that I am not capable of doing the subject justice, as the question at issue is one of vital importance, and also one which I have seriously considered; I will, nevertheless, answer you to the best of my ability.

You will pardon me, I am sure, if I touch upon

*Va. Med. Mo., May, '93.

certain phases and relations of the matter which you have expressly intimated should be left out of our correspondence. I believe in "taking the bull by the horns," and do not consider it justifiable to leave any salient point untouched. I know the liberality of my Southern friends—of whom I believe no Northern doctor has more than myself—and I feel certain that they will take all that I may say, exactly in the spirit in which it is written. Believe me also when I state that any bias which may appear to be in favor of what has been termed the "Southern method" of dealing with the criminality of the negro, is by no means due to desire to pat my Southern friends upon the back, but is based upon absolutely independent reflection. I know that this statement to you, who know me so well, is unnecessary; but it is well to remember that this is an open letter, and liable to misinterpretation—willful or otherwise. So much for my platform.

The term "sexual perversion," as applied to the class of crimes committed by the negro to which you allude, cannot, in the strictest sense of the term be justified scientifically. Sexual perversion, in the abstract, implies an aberration of the sexual passion which impels to abnormal methods of gratification with the opposite sex or methods (necessarily abnormal) with the same sex. The only qualification in the case of ordinary rape is that involving criminal assault upon children. Here, strange to say, we often find a class of cases where the criminal has no desire for female adults, but for female children only. I, of course, cannot exactly say how frequent such cases are among the negroes, but I firmly believe them to be relatively more frequent among the white race, in whom it may be either inherent or acquired. Rape, however, under the stimulus of this abnormal passion, is not so liable to be perpetrated by the white man for the reason that certain inhibitory influences, such as pride, fear of punishment and ordinary self-control, are more effective in the white than in the black race. Relative to this form of sexual perversion, I will call your attention to the *Pall Mall Gazette* exposure in London some years ago.

I might remark in passing that, notwithstanding the horrible crimes perpetrated under the influence of the *furor sexualis* by the negro, particularly in the South, I believe that he compares quite favorably as regards sexual impulses—taking all abnormalities into consideration—with the white race. The more I see of white men in so-called refined society, the more contempt I have for quite a large proportion of male humanity. This may not be relevant to the subject under discussion, but still it is worthy of consideration.

In recent conversation with an intelligent prostitute who happened to be under my professional care, I was informed that the men who seek houses of ill-fame for the purpose of having their perverted sexual impulses gratified, are chiefly to be found among the high-toned clubmen and ultra-fashionables. When we consider the favorable circumstances under which such men are placed as regards inhibitory influences, the excessively developed sexual propensity of the negro, while horrifying in its criminal results, is not more appalling than the sexual crimes of his white brother.

In considering the special causes which account for the frequency with which the crime of rape is perpetrated by the negro in this country, several factors must be taken into consideration.

1. *Hereditary influences descending from the uncivilized ancestors of our negroes.* When we take into consideration the ancestry of the American negro, and reflect upon the peculiar sexual relations sustained by that ancestry, it is by no means surprising that ancestral traits crop out occasionally. Marriage among certain negro tribes is as close a simulation of what is designated as rape in civilized communities as could well be imagined. When the Ashantee warrior knocks down his prospective bride with a club and drags her off into the woods, he presents an excellent prototype illustration of the criminal sexual acts of the negro in the United States. You will understand, my dear Doctor, that this argument does not apply alone to the negro, for I believe that sexual crimes on the part of white men are due to a similar atavistic manifestation of savagery. Many centuries of civilization, with an inherent as well as required capacity of appreciation of those social obligations which constitute the greatest good to the greatest number, have done much for the white race—which is essentially a mixed type, after all. Consider on the other hand, how short a time such influences have been brought to bear upon the American negro. Consider, also, if you please, that the evolution of the negro can be only said to have fairly begun with his liberation, for then, and then only, did he become an independent factor in the body social.

2. *A disproportionate development of the animal propensities incidental to a relatively low degree of differentiation of type.* A disproportionate development of the animal propensities associated with a relatively low differentiation of type is necessarily involved in the preceding factor of heredity. It is a racial characteristic, and one which, for physical reasons, cross-breeding will never eliminate, for the reason that cross-breeding in the case of the negro means eventually his destruction. The line of demarkation between the negro and the Caucasian races is too strongly marked to result otherwise. Cross-breeding, which is so beneficial in improving the stock in some instances, fails altogether in the case of miscegenation of the white and negro races. The result is a degenerate type which very frequently has all the evil propensities of the negro *plus* those of the white man, associated with a physique of a much more degenerate type than either of the ancestors. When, however, certain inhibitory influences characteristic of the higher type of the white man are well developed in the mulatto, as they are likely to be from acquirement—by a more intimate association with the white race as well as from white heredity—the mulatto may be much less liable to sexual crimes than his negro ancestor

3. *A relatively defective development of what may be termed the centers of psychological inhibition.* This defect is characteristic of all races of a low grade of civilization and a relatively low grade of intellectual development. This with some races might in time be corrected; but it certainly has not yet been corrected in the case of the negro, nor do I think that it ever can be corrected in the negro as a distinctive racial type.

4. *Physical degeneracy involving chiefly the higher and more recently-acquired attributes, with a distinct tendency to reversion of type, which reversion is especially manifest in the direction of sexual proclivities.* This will at once appeal to you as a rational proposition, and it is as true as the law of evolution itself. It applies not

only to the negro race, but to all races. It applies, perhaps, with especial force to the race under consideration.

When a race of a low type of development is subjected to an emotionally intellectual strain, inhibitory or restraining ideas and impulses are affected, and the primitive instincts bring to the surface manifestations of lust or bloodthirstiness, singly or combined. The Anabaptists of the Lutheran Reformation threw all restraint to the winds and indulged in sexual murders. These Anabaptists were chiefly serfs, who had been inflamed by fallacious notions of the clergy emanating from the time-honored text: "And they (the disciples) had all things in common, in love preferring one another." That influences of this character affect the negro in consequence of the preaching of that equality which degrades, is witnessed by the circumstance that the cases of insanity due to the physiological commotion of puberty are thrice as frequent in Illinois as in New York. In New York, negroes owning a certain amount of property had been allowed to vote for at least forty years prior to the war between the States. The negro had been gradually evolved into a phase of theoretical equality as regards his citizenship, which led him to measure matters by the highest standard possible to his own race. Such a condition of things necessarily imposed inhibitions upon his animality. The negro, under these circumstances, could not consider himself the victim of oppressive laws formulated by the whites, as his own race for several decades had functionated in lawmaking. Law, therefore, with such negroes, was to be respected rather than condemned. The reverse was true in Illinois, in which State the negro passed with one bound, from a condition of serfdom, in which there was no stimulus to independent thought, to an insolent assumption of superiority. The old adage that "if you put a beggar on horseback he rides to the devil" would apply very accurately to the negroes thus suddenly thrown upon their own responsibility.

The influences which I have enumerated are even greater in our Southern States, in which the delusion of "forty acres and a mule" very soon destroyed the compulsory thrift characteristic of the negro in slavery. Remember, my dear sir, that slavery merely bottled up the primitive instincts of the negro race; it did not destroy those instincts. All there was of thrift and decency in his character was impressed upon him in a more or less arbitrary manner by his owners. It was not the product that evolution which has characterized the negroes of New York State, for example, who have been more or less segregated, and in a general way have been exposed to an environment favorable to their evolution. The influences of carpet-bag government, as depicted in Pike's "Prostrate State," were a very powerful factor in destroying negro respect for law and order in the South. I cannot lay as much stress as I would like to do upon this point for lack of time; but the indoctrination of the fallacious and pernicious teaching of the carpet-bagger (which gave the degraded negro an exaggerated estimate of his own personal importance as based upon the market value of his vote, and also imparted to him the idea that behind him, as he went to the polls, stood a phantom army of Republican soldiers with bayonets fixed) has done much to increase the insolence and criminal impulses of the negro in the South.

5. *The removal of certain inhibitions placed upon the negro by the conditions which slavery imposed upon him; these were removed by his liberation.* This I consider to be by far the most important factor in explanation of the frequency of sexual crimes among the negroes of the South at the present day. Remember, please, that the negroes were simply goods and chattels; independence of thought and action was with them more theoretical than practical, and certainly had very little bearing—in whatever degree it may have existed—upon their relations with the white race. They were accustomed to obey the dictates of their owners, whatever those dictates may have been. Their environment was narrow; their conditions for development from the standpoint of an appreciation of their relations to the body social were peculiar; their thinking was largely done for them by others. Indeed, the necessity for independent thought and action did not exist as you and I understand it to exist among the white race. Attachment to the families of their masters, a general sense of obligation to the latter for their own sustenance prevailed. Privation and want—those frequent causes of degeneracy—were unknown among them. Personal responsibility of a physical character for crimes and misdeeds was a prominent factor of their daily lives. Corporeal punishment for misdeeds was more awesome to them at that time than is the fear of the bullet or rope to-day. Some of the inhibitory influences of plantation life were due to colonization; that is to say, mass influence was felt. The desirability of good behavior—indeed, the absolute necessity for it—was a dominant influence pervading each little negro community.

Again, as far as sexual impulses were concerned, the negro on the plantation had more facility for matrimonial alliances—notwithstanding the possibility for separation by the sale of one or the other of the contracting parties—than the average negro at the present day.

I will not dwell exhaustively upon the evil influence of certain individuals among the whites in the South who were not inclined to respect even the sexual rights of their goods and chattels; but I will take the liberty of stating, in passing, that in some cases in which the negro has exhibited an inappreciation of his proper status from a sexual standpoint, he may have had rather a bad example set him by his white brethren. I do not think that this particular point is by any means as important as certain Northern blatherskites have endeavored to make us believe; still I cannot help recalling a remark which a rather fast young man from the South once made to me, which was to the effect that a young man who fornicated was not apt to injure his social standing even though his indiscretions were known, provided he confined his indulgence to prostitutes and negroes. A single instance of this kind may do an incalculable amount of damage to the Southern-Caucasian side of the negro question.

In concluding this etiological division, I will state that it should be by no means surprising that the negro, when thrown upon his own responsibility, with a complete removal of all the inhibitory influences of his previous bondage, should be unable to adapt himself to his new environment. This is by no means apologetic for the criminal acts of the negro, but is simply an argument worthy of the consideration of those sentimental idiots who believe that the negro question is one entirely of skin and political complexion. Such sentimentalists will one

day awaken to a realization of the fact that the negro question is one of the most serious with which we are confronted at the present time, and one which may be settled by the physical degeneracy and death of the negro race, but which can only be settled in that way. It certainly cannot be settled by political manipulations of any kind, or by sentimental arguments.

6. *An inherent inadaptability to his environment both from a moral and legal standpoint, the result of this inadaptability being an imperfect or perverted conception of his relations to his environmeut—i. e. to the body social.* This inherent inadaptability to environment, while applicable to the negro race in its savage condition, is by no means so potent in its influence as in civilized communities. In his primitive condition, the social environment of the negro consists of a very simple system, adaptation to which is a comparatively easy matter. Placed in the midst of refined civilization, ad aptation to environment becomes at once a matter of great difficulty.

We must consider also the fact that the first real attempt on the part of the Southern negro to adapt himself to his new surroundings in this country began with the close of our Civil War. Prior to that time, as I have already outlined, the negro could hardly be said to be an independent factor, nor did he have an opportunity of demonstrating whether or not he was capable of adapting himself to his surroundings, for the simple reason that he was under the domination of guiding, intelligent individuals of a superior, more civilized and more refined race. Consider also the fact that the South has only recently fairly emerged from the unsettled condition which the disturbed social, financial and political relations incidental to our most terrible war imposed upon it. Indeed, the magnificent possibilities of the new South are even yet unappreciated by other sections of our common country. Even the Southern people themselves, I firmly believe, have not appreciated as they should the great resources of what I personally consider the grandest portion of the United States. With political turmoil, commercial confusion, social disintegration surrounding them, is it a great wonder that the negro, suddenly thrown upon his own resources, should develop highly criminal tendencies? Loyalty to the master, respect for the mistress, and affection for the children of those who once cared for him, melted away like dew before the sun under the fortuitous circumstances in which he was suddenly placed, and with the disappearance of the old-time slave, in whose mind many inhibiting influences of slavery still remained, and with the incoming of a new and more degenerated generation of his descendants, it is little wonder that criminality on the part of the negro should have increased in the South. Taking into consideration his disproportionate sexual development and propensities, it is by no means surprising that with the removal of inhibitions sexual crimes should result.

Inadaptability to environment is by no means confined to the negro race. We have found that some other alien races imported into this country have been social, political, moral, and commercial misfits. The Chinaman will never make a good citizen. Fortunately, however, his natural instincts do not partake so much of the animal type as is the case with the negro, for the Chinaman of to-day is the product of a comparatively high grade of civilization, or semi-civilization, which has prevailed for many centuries, and which has developed certain inhibitions upon the purely animal propensities. The artistic talent of the Chinese is in itself an evidence in favor of this argument, for *pari passu* with the development of a taste and faculty for artistic pursuits there occurs a development of the higher inhibitory faculties. The industry of the Chinaman in his natural condition—to say nothing of that which is exemplified in his relations to our community when he settles among us—is another factor to be taken into consideration.

The natural shiftlessness of the negro, when left to himself, is simply a reversion to the primitive type, which is well illustrated by the Zulu, who is content with a breech-clout, a plentiful supply of grease for his glossy hide, and plenty of wives to ministers to his various appetites. Let me again emphasize the fact, that it has been but a short span between the Zulu and the negro as we see him to-day. How much of inhibitory faculties could we expect to develop in a race, primarily so barbarous, within so short a time?

7. *An incapacity of appreciation of the dire results to himself of sexual crimes:* This incapacity is quite characteristic of individuals of a low type of organization, and such little sense of personal responsibility as a large proportion of the negro race possesses is readily inhibited by excitement of the lower brain centers, such as may be produced by anger, alcohol, or the *furor sexualis*. It has been my experience that individuals of refined nervous organization and sensibilities are more likely to hold a wholesome respect for capital punishment than those of a lower type. A keener appreciation of their present existence and a greater dread of the possibilities after death certainly actuate such persons. The higher faculties of the brain, those of reason and ideation, are relatively more strongly developed than in the lower types of humanity, and there exists a proportionate lack of development of the lower or more strictly animal centers. When, therefore, a struggle for the mastery arises between the reasoning faculties and animal impulses, the balance is very likely to be in favor of the former, particularly when the keen sense of personal responsibility comes into play.

You will pardon me, I am sure, when I say that the seeds of religion sown upon the soil of ignorance and superstition characteristic of the negro have had much to do with the development of criminality in the negro race. I sometimes wonder whether no religion at all would not be better than any religion for a large proportion of individuals among the negroes. It is said that most executed criminals go from the scaffold straight to heaven. I doubt whether there ever was a negro who did not believe that he was heavenward bound as he stood upon the scaffold or confronted the righteous indignation of the citizens of the community in which he had committed an outrage. We have not so very far to look backward from the pious and superstitious negro upon the scaffold, who believes that he is on the short-cut to Heaven, to the Zulu, who in battle courts death because the heathen religion of his fathers has taught him to believe that an eternity of happiness lies just beyond his enemy's spear or bullet.

The same superstition animates the Mussulman, who, as the charging hosts of the "accursed Frank" pass over his wounded body, hamstrings the horses or spears the riders, in a desperate attempt to bring

death upon himself that he may go straight to the arms of Mohammed in the Paradise of the faithful.

When all inhibitions of a high order have been removed by sexual excitement, I fail to see any difference from a physical standpoint between the *sexual furor* of the negro and that which prevails among the lower animals in certain instances and at certain periods. This is not confined to the negro, but is true, although less frequently, in certain instances of sexual criminals among the white race. Kiernan, in the *Journal of Nervous and Mental Diseases* in 1885, called attention to a fact which is very pertinent to our present inquiry—namely, that the *furor sexualis* in the negro resembles similar sexual attacks in the bull and elephant, and the running amuck of the Malay race. This *furor sexualis* has been especially frequent among the negroes in States cursed by carpet-bag statesmanship, in which frequent changes in the social and commercial status of the negro race have occurred.

The reversion of type in the negro is both physical and intellectual, and must be taken into serious consideration, as bearing directly upon the question: is it practicable to remedy the resulting evils by either legal or illegal methods of punishments?

An interesting story is told by the cannibalistic sexual rites of Hayti and Liberia and the enormous increase in Southern Voodoo Phallic worship since the War. When sexuality finds vent in phallic worship it is relatively harmless as regards the individual. When it cannot be vented in this manner it results in sexual crime.

The greater frequency of rape by negroes in the South as compared with the North is, I think, indisputable and requires greater consideration. The climate of the South is much more favorable to the perpetuation of the primitive impulses of the negro race than is that of the North. A reversion of type—both physical and intellectual—is more likely to occur under the influence of that climate which most nearly approximates that in which the negro race was originally bred. The influence of climate upon the sexual function has a powerful bearing not only upon the negro race, but upon the Caucasian. The relatively unsettled condition of the South after the War as compared with the North—to which allusion has already been made—has had much to do with the comparatively greater frequency of sexual crimes.

Again, the Northern negro has necessarily been surrounded by more inhibitory influences than the negro of the South. The lower class of whites with whom he has most frequently been brought in contact, have been better situated as regards opportunities for honest industry. They have been by virtue of the climate more energetic, and this necessarily must have had a certain degree of influence upon the negro. The North has been more prosperous, and consequently the opportunities for obtaining a comfortable subsistence have been better for the negro than in the South. The negro of the North has not been so much subjected to the mass influence—*i. e.*, he has been more individualistic than in the South, where large numbers of negroes are found together. In order that civilization should have a fair chance to influence the negro, he must have more opportunities for segregation than in the South.

The enormous increase of the negro since the War has had much to do with his physical and intellectual degeneracy and therefore with his criminal propensities. As man descends in the scale of differentiation, the number of offspring at a birth approximates the multiple pregnancies of the lower strata of animal life. Morel, De Monteyel, Hagen, and one of our most eminent American writers—Kiernan—have conclusively shown that multiple pregnancies are most frequent among the degenerate types of humanity. The offspring in such multiple pregnancies are defective from an obvious double cause; upon them all degrading influences act with greater power.

Your remarks, my dear doctor, anent the quality and quantity of food eaten by the southern negro since the war, as compared with that which he obtained before the great struggle, have, I think, much weight; but I do not think they have so important a bearing upon the question which you have done me the honor to submit to me as the lack of systematic occupation and the forced assumption of responsibilities for which he was, by nature and training, unfit—to say nothing of the acquirement of vices and profligate indulgence for which he had relatively few opportunities while he was in bondage, and for which he was directly responsible to those whose interest it was to keep him in the best possible condition morally and physically.

I can only compliment you, sir, upon the comprehensiveness with which, in a general way, you have, in your letter, covered the causes of physical degeneracy and the present extraordinary prevalence of diseases of nutrition among the negro race, particularly as seen in the South.

Although I have discussed most of the points which I believe should be incorporated in my reply to your communication, I feel that I cannot leave the subject without touching upon certain points in which I fear many of my southern friends will not agree with me. These points involve a consideration of a remedy for the alarming prevalence of sexual crimes among the negroes of the South. It is hardly necessary to state that I am not going to discuss this question from the standpoint of political buncombe, maudlin sentimentality, and intentional bias of certain blatherskite newspapers in the North. I shall be as utilitarian as possible; whether I am philosophical or not, must remain for you to judge.

You speak of the "unwritten law of every community in the South, from which there is no appeal. Now, my dear doctor, what has been accomplished by this law? In answer to this question, I have only to quote your assertion: "Sexual crimes on the part of the negro in the South are becomming more and more frequent." This is all, I believe, that it is necessary for me to say with regard to the general utility of the practical application of your "unwritten law." I do not say that lynch law is always ineffective, for I spent the earlier years of my life in a community in which it was most decidedly so. One of my earliest recollections was that of the exploits of vigilance committees and those decidedly informal trials held by Judge Lynch in the early days of the history of California—my native State. The conditions, however, which prevailed at that time were decidedly different from those which prevail in the South. Judge Lynch has accomplished great good in many isolated instances in this country. It has only been in isolated instances, however, and under special and limited conditions, such as those involved in temporary emergencies due to local lawlessness. Lynch law, however, has seemed to have too large a contract upon it hands in the Southern States, as far

as the acts of lawlessness at present under consideration are concerned.

Before going further, perhaps it might be well for me to place myself upon record as opposed to capital punishment, legal or illegal. From a sentimental standpoint? Most emphatically, No. From a utilitarian standpoint, I have failed to see wherein capital punishment has, in the aggregate repressed those crimes for which it is prescribed. The census returns show the lowest proportion of capital crimes in this country is in the three States in which capital punishment has been abolished. Even in the olden days of public and bloody executions capital crimes were none the less rampart because of these executions. On the contrary, capital punishment seemed to have a direct effect in increasing the savagery of, and lessening the respect for human life entertained by, the the body social. No matter how scientifically and legally an execution may be done, it is still a sacrifice of a human life, and as such has a demoralizing effect upon the community. If, then, this be true, and capital punishment fails of its object, wherein can it be condoned?

I am not inclined to captiously criticise, mind you, the typical Southern method of dealing with negro ravishers—for I would probably be as quick to act similarly under like circumstances—but do you think that any reasoning whatever could justify the recent roasting of a negro ravisher in one of the Southern States? The punishment of that negro, while well deserved and horrible enough to satisfy the most epicurean taste from the standpoint of revenge, could not possibly be any more effectual than if his life had been taken in a more humane manner by the bullet or rope.

With the departure of the vital spark from that negro all impression made by the execution, as far as he was concerned, ceased. To the negro population of the country, however, an impression was conveyed to the effect that a barbarous discrimination against one of their race had been exhibited. The justice of the punishment in that case will ever be obscured by the barbarity of its execution. The impression made upon the community in which it happened can be imagined.

I object to any method of punishment which is followed by forgetfulness on the part of surviving prospective criminals. With them, current events soon obliterate all recollections of the criminal, his crime, and its punishment.

To my mind, there is only one logical method of dealing with capital crimes and criminals of the habitual class—namely *castration*. This method of punishment leaves behind it evidences which will prove a wholesome warning to criminals of like propensities. It prevents the criminal from perpetuating his kind. The murderer is likely to lose much of his savageness; the violator loses not only the desire, but the capacity for a repetition of his crime, if the operation be supplemented by penile mutilation according to the Oriental method. A few emasculated negroes scattered around through the thickly-settled negro communities of the South would really prove the conservation of energy, as far as the repression of sexual crimes is concerned. Executed, they would be forgotten; castrated and free, they would be a constant warning and ever-present admonition to others of their race. Thus, I believe that castration would be peculiarly applicable to the class of criminals under consideration; while, at the same time, claiming that it is the rational method of dealing with the crime question in many of its phases.

I cannot leave this subject without allusion to your remark that the moral and physical degeneration of the negro will eventually destroy the race upon this continent. This, I think, is true; but it is not, after all, a remedy worthy of consideration, for the more degraded a race becomes the more frequent crimes against law and order will become. While perhaps it would not be desirable to prevent the inevitable in the case of the negro, there might be much of benefit to ourselves in retarding the march of the inevitable as long as we can by improving the physical condition and status of the negro race. Manual training and education will do much for the negroes of the South; and if our government in the past had paid more attention to these factors in the development of the negroes, who were suddenly thrown upon their own responsibility, and less attention to the cultivation and harvesting of the negro vote, it would have been far better for the South.

Few, indeed, of the people in the North, can appreciate the terrible burden which the liberation of the slaves threw upon the people of the South. I believe that slavery was wrong as firmly as I believe anything; but it really was a pity to throw the burdens of this wrong—which originally was legalized, encouraged, and fostered by practically the entire country—upon that section of the country to which it was finally confined. As a matter of fact, the negro was turned loose to seek his own salvation; and aside from the influence of carpet-bag politics and a decidedly warm interest in his vote, practically nothing was done by the government to ameliorate his condition or to improve his intellectual and physical status. The burden imposed upon the South was still greater on account of the impoverished and demoralized condition of the white people in that section, resulting from the great struggle between the States. What has been done since the War, aside from the political interest in the negro exhibited by the Government, has been of a sporadic character, and due to individual philanthropy on the one hand, or an appreciation on the part of the Southerner of the necessity for self-defense by the improvement of the negro, on the other.

With respect to amalgamation of the negro and white races in this country, we are confronted with a very trying problem. The progeny of cross breeding often has all the vices of both ancestors and the virtues of neither. He is also physically degenerate. I doubt that he has, as a rule, as well-marked impulses of a purely animal nature as characterizes the negro element in his ancestry. One great difficulty in the case of cross-breeding of white and negro is the everlasting tendency to a reversion of type, which atavism results quite uniformly in the development of the negro type.

On the whole, I am inclined to think that, with proper educational and physical training of the individuals of mixed blood, extensive cross-breeding may eventually be of value in the solution of the problem which you have submitted to me. The prejudice and legal restrictions which attempts at miscegenation has ever met with in the South, have perhaps after all, not been conducive to the final improvement of the relations between the two races. It would hardly be becoming in me to advocate mis-

cegenation. I simply desire to raise the question whether or not, from a utilitarian standpoint, its general application would eventually solve the problem of "What shall we do with the negro?" Permit me to say that none of the arguments that I have ever been able to formulate, and none of the opinions that I have ever read, have enabled me to see in the negro question anything but a most perplexing, harassing and important problem, of which the question you have done me the honor to present to me for consideration is by no means the least important. It may be selfish in me, but I am rather thankful that the responsibility of solving the problem in a radical manner—and such radical solution must come sooner or later—will necessarily devolve upon another generation than my own.

A point well worthy of attention, in seeking to remedy the evils which so vitally interest the Southerner, is this: Much may be done with the negro by a proper example on the part of the white race, which must of necessity be his model, socially, politically and morally. Ignorance of sexual physiology has led the average white boy, at the age of puberty, to believe that fornication is a necessity, or, at least, a luxury at which the whole world winks. You know only too well the train of misery following the indoctrination of such ideas. This fallacious idea is responsible for much of prostitution and sexual crime. Parents abhor its discussion; physicians abhor it as a *bete noir*. Sentimentality and morals aside, the most materialistic of us must acknowledge that sexual puberty is wholesome in its effects. The remedy for the evils of youth and early manhood, is, never to begin indulgences that create physical and injurious necessities.

In conclusion, my dear Doctor, permit me to state that I am fully aware that I have not adequately discussed the question which you have submitted to me. I fear, moreover, that my reply may be unsatisfactory to you; but I assure you that I am ready to receive more light upon the subject, and am decidedly open to conviction.

Thanking you for your kind consideration and the compliment which you have paid me, I have the honor to remain,

Very fraternally and faithfully yours,

G. Frank Lydston.

Clinical Lecture.

By Harold N. Moyer, M. D.

Neurologist to Cook County Hospital, Adjunct Professor of Midicine Rush Medical College.

Polio-myelitis Anterior Infantile Spinal Paralysis—Upper Arm Type of Remak, without Involvement of the Supinator Longus.—Gentlemen: This patient, a little girl, comes to us for a paralysis of the right arm. She is five years of age and has a good family history. There are four children in the family, all of them well. She is the second child; the mother tells us that her labors at the time this child was born were easy and that no instruments were used. She thinks the birth was two months before full term. The child was well and strong until nine months of age, at which time she is said to have had a heat stroke. On this occasion she was on the veranda of the house in care of a nurse girl. She was fully protected from the direct rays of the sun and was asleep at the time; later she awoke crying and had considerable fever, on the following day the fever had greatly increased and she was not expected to live. On the third day paralysis of the right side came on. The mother is positive that at no time was there any deviation of the facial lines, but the right leg and arm were completely helpless. After the fever subsided the child began to get about slowly, and at the end of some months she could walk as well as ever, but the arm remained in the same helpless condition in which you now see it.

You notice that there is an absolute inability to carry the elbow outward from the body, the shoulder can only be slightly raised. The forearm cannot be flexed. There is a marked disparity in the size of the two arms, the right being much smaller. The same condition is noted in the forearm, and the right hand is smaller than the left. The projecting bones about the shoulder show that the muscular tissue composing the deltiod, biceps, supra and infra spinatus has largely diappeared. Flexion and extension of the fingers still remain, but the grasp of the right hand is very much weaker than the left. Station and gait are unimpaired. Sensation is normal in both upper and lower extremities and is, if anything rather more acute in the affected arm. The paralyzed limb is distinctly colder than its fellow. The superficial and deep reflexes are normal excepting those of the right arm. The pupillary reflexes are unimpaired.

I would especially call your attention to one point in the history as given by the parents; they infer that this child had a heat stroke just before this attack came on. A not infrequent circumstance in the history of infantile paralysis is the statement that some accidental association stands in the nature of a cause. In this case there is not the slightest evidence that the child had a heat stroke, but in casting about for a cause of the paralysis they accidentally hit upon this idea.

The case illustrates one of the less frequent forms of spinal palsy in children and confines Remak's statements that the paralysis is often in muscular groups that are associated in action. It refutes however one statement of Remak that the supinator lungus is paralyzed in the upper arm type of atrophic paralysis, along with the deltoid, brachialis anticus and biceps muscles.

The gray matter in the anterior horn was affected with a severe inflammation at the time this disease appeared. The segments that were most seriously affected were the fifth and sixth, but the fourth, seventh and eighth did not by any means escape. We may compare this inflammation to a conflagration that is occasionally seen in a block on one of our city streets, one or two houses are completely destroyed, the adjoining ones are scorched and still farther along they are smoked and discolored. So in this case we have had a restoration in some muscles while others are completely wasted, owing to the destruction of the trophic center. In this case there are no signs of contracture or deformity, so that we do not need to look out for these conditions as we might have to do if the disease were found in the lower extremity. There is nothing that can be done in these old cases. The muscles are wasted and nothing we can do will restore the functional activity of the paralyzed limb. We can only recommend that massage be used to maintain the circulation and that the limb be carefully protected, as the bones are exceedingly frail and are liable to fracture.

HICCOUGH ASSOCIATED WITH HYSTERIA, EFFENCIENCY OF THE GALVANIC CURRENT IN CONTROLLING THE SPASMS.—As you look at this patient you see she is affected with hiccough. The paroxysms are fairly regular, about fourteen to eighteen times in a minute. She is nineteen years of age, a Bohemian by birth and has recently come to this country. She says that the disorder began two days ago. She was alighting from street car, when the vehicle suddenly started before she had stepped down. She was not thrown nor did she fall, but simply had to step rapidly and was greatly frightened. At once the hiccough began and has continued without interruption during the waking hours. You notice that the spasm is painless, though the patient looks distressed and worried. We learn that she has had two similar attacks, the first one some three years ago and the second about one year later. The second attack lasted about four months, the disorder passing off gradually. Of the previous attacks one was caused by fright and the other followed a fit of anger in which she was greatly excited.

Singultus or hiccough is essentially a clonic spasm of the diaphragm in which the glottis is surprised, as it were, and a column of air is forced through and against the vocal cords while they are in varying states of tension and aproximation. This accounts for the wide difference in pitch of the sound as observed in different cases. About the same range of pitch and the same rythm is observed in the same patient. In this girl the contractions run fairly even, from fourteen to eighteen in the minute. Cases have been noted in which the spasms reach the enormous total of one hundred in the minute.

Of the exact pathology of this condition we know little. By the older writers it was regarded as an involvement of the phrenic nerve and diaphragm. This was denied by Bright and Romberg, the former having seen two cases of disease of the phrenic nerve in which there was no sign of hiccough. Later writers have again come to the conclusion that there is some involvement of the respiratory center, which is reflected along the phrenic nerve and there is considerable evidence that changes in the nerve trunk or its endings may cause the disorder. A study of the clinical cases so far reported, shows a wide variation in etiology. As a symptom occurring in the continued fevers, cachexia and other constitutional states it is frequently of the gravest importance. When it occurs in nervous women accompanied by hysteria as it is in this case it need excite no apprehension. There is usually little or no pain, simply some discomfort. It lasts for days, months and even years. One case described by Romberg had existed for six years. In these cases the trouble may be exceedingly rebellious to treatment. In the lighter forms of the trouble such simple methods as holding the breath, making a number of deep and quick inspirations or rapidly swallowing a liquid may be sufficient to interrupt the paroxysms. Cruveilhier mentions two cases of severe singultus that were relieved by having the patient's head held downward and backward and then pouring water into the mouth, partly suffocating the patient and causing violent reflex vomiting and coughing. In the milder and more persistent cases, associated with hysteria and neurasthenia, the associated disorder must be treated, therefore, we shall direct for this patient nerve tonics and iron to improve the evident anæmia. Electricity has been mentioned as efficient in controlling the spasms. Bartholow recommended the faradic current applied along the attachment of the diaphragm. A strong current applied in this way, you see, causes a violent contraction of the upper portion of the abdominal muscles, but, as you observe, no diminuation of the spasm. The constant current applied with the positive pole at the back and root of the neck and the negative pole at the epigastrium causes the number of spasms to fall to four in the minute. As soon as the current is discontinued they increase and reach the full number. Accordingly we shall put this patient on a general tonic treatment and direct the application of the constant current daily.

TERMINAL DEMENTIA-EXPOSURE TO LEAD-NEUROTIC HEREDITY.—The young man who now comes before us is an inmate of a hospital for the insane, where he has been confined for the past three years. He is accompanied by an attendant. You observe his quiet manner and the general air of intelligence about him. At first sight it scarcely seems possible that there should be anything the matter with him serious enough to require his detention.

His mother, who accompanies him, says that the family history on the paternal side is free from neurotic heredity, but three maternal uncles were inebriates, and one was a complete wreck. Now it makes no difference what answer you make to the *questio vexata*, is inebriety a disease? It is safe to assume a neurotic heredity where inebriety appears in the ancestry. As a child we learn that he was nervous and early developed a decidedly artistic talent. He is twenty-seven years of age, and was married six years ago; has two healthy children. Some seven years ago he took up house painting and decorating, and we learn that for more than four years prior to the outbreak of his mental trouble he was engaged in mixing and using lead colors.

We are not able to obtain a very clear history of the mental trouble which first sent him to the hospital three years ago, but we learn that he was restless, noisy and sleepless. The patient remembers nothing of what took place then nor for some weeks afterward. It is probable that the attack was one of simple mania. After some months he was in substantially the same condition in which you see him to-day.

On questioning him regarding his early history and recent events it is apparent that his mental processes are exceedingly slow and labored. He knows that he has two children, but cannot give their ages or state when they were born. On being asked how old a person would be now who was born in 1887 he answers three years. He shows more deficiency in this respect than is normal in a man of his previous social condition and education. The loss of memory does not extend to positive gaps, but simply that there is slowness in recalling things and that the outlines are indistinct and blurred. This condition is very different from that noted in paretic dementia in which lacunal are found in which events, names and dates are often completely obliterated.

No delusions can be elicited and there is absolutely no trace of emotional disturbance. The bodily health is excellent, the appetite, circulation and digestion, and eliminative functions are admirably carried on. There are no signs of somatic disturbance in the nervous system.

It is apparent that we have here a case of terminal or secondary dementia, a class composing such a large proportion of our asylum population. You may well ask, why if the young man is so quiet and well behaved he is not allowed to leave the hospital. This has been tried, but each time that he comes out he is soon excited, incoherent and noisy, and has to be returned to the hospital. In a few hours or days he is again quiet. This is quite characteristic of many of the terminal deteriorations. As long as they remain in the hospital they are quiet and even useful. But as soon as they come out in the world their weakened mental state gives way, the emotions become exalted and they then present a secondary confusional insanity.

The young man confesses to a venereal infection some ten years ago. On examination we find several deep scars on the side of the glands penis. So far as he can remember there were never any signs of secondary syphilis. The character of the attack, depth and extent of the scars and absence of all glandular involvement would lead us to think that we had a case of chancroidal disease without systemic infection. There remains therefore the two remaining factors to be considered, the heredity and exposure to lead. We learn that there has been obscure pains about the loins and abdomen for years. They are less now. We need hardly look for the blue line on the gums or other evidence of recent lead poisoning. They have long since disappeared. The psychoses directly caused by lead are usually accompanied by degeneration of the nerve elements of the brain and the general picture of paretic dementia. We should hardly look for a psychosis of this kind as a direct result of lead, but it is to be remembered that like other toxemias there is a profound nutritional disturbance. This in connection with the neurotic heredity, which is further shown by the stigmata of degeneration, an asymmetrical skull and small and badly shaped ears, are sufficient to account for the mental overthrow.

The prognosis in these terminal deteriorations is exceedingly unfavorable. Nothing is to be looked for from drugs. By a long process of training and education in a case no worse than this he may be able to live outside of a hospital and pursue some simple occupation. But he will always show that he is a damaged man and there will be a tendency to fall into a secondary confusional state.

Neuritis of the Median Nerve.—This man was referred by a surgeon for our opinion as to the advisability of an operation for the restoration of the nerve supply of the right hand. Some three months ago he received a cut on the inner side of the wrist, the scar of which still remains. He resorted to some domestic applications and as a consequence the wound became infected, an acute cellulitis was set up and to relieve tension several incisions were made, one in the palm of the hand and two on the forearm.

The thumb, index, middle and adjacent sides of the ring fingers show almost complete anæsthesia of touch and temperature both on the palmer and dorsal surface.

There are no tropic disturbances such as would be shown by glossy skin, loss of nails, etc. The electrical reactions of the interossei and muscles of the thumb and little finger are normal to both faradic and galvanic currents. There is considerable loss of power of flexion of the fingers amounting to about one-half as compared with the left hand. The patient complains of no pain but only of numbness in the anæsthetic area.

The questions naturally presenting themselves in this case are; *First*, Was the nerve divided? *Second*, Is there pressure of a cicatrix upon the nerve? *Third*, Is it a case of peripheral neuritis? It is apparent that a correct answer of these questions will determine whether surgical interference is warranted at this time. On questioning him closely we learn that the anæsthesia was not noticed *immediately* after the incisions were made but came on sometime later and at no time was there a complete loss of motion. These points are sufficient we think to exclude an immediate derision of the nerve. Pressure from a cicatrix is, we think, excluded by the fact that sensation is impaired to a greater degree than motion, contrary to the rule observed in cases of pressure paralysis in which while sensation is the soonest disturbed yet motion is the last to be restored. We confess that the problem is a difficult one, yet the greater probability is in favor of a peripheral neuritis, particularly as the condition for which these incisions were made was an infectious cellulitis which might readily extend to the sheath of the nerve. We shall therefore recommend that no surgical operation be undertaken but the treatment appropriate for peripheral neuritis be employed.

Proceedings of Sccieties.

Philadelphia Academy of Surgery.

Meeting April 3, 1893. The President, Dr. William Hunt, in the Chair.

Two Cases of Amputation at Shoulder Joint in Which Wyeth's Pins, to Control Hæmorrhage, Were Used.

By John H. Brinton, M. D., Philadelphia.

Case I. *Osteitis deformans of the leg, followed at the expiration of twenty-three years by sarcoma of the humerus; amputation at shoulder joint by the oval method; use of Wyeth's pins to control hæmorrhage; death on the tenth day.*—E. B., aged forty-eight years; born in Massachusetts; publisher. About twenty-three years ago he noticed tenderness over the right tibia, increased by pressure, by severe or prolonged exercise, and by barometric changes. Various antirheumatic measures were employed, but without avail. The limb did not become much worse; he was able to be about and follow the business of his life for years. During this time he was not lame, but experienced a sense of weakness in the limb. To use his own expression, "he favored that leg." In the course of years the bones of the legs had gradually increased in thickness, and had become curved. About ten years ago he consulted the late Prof. Agnew, who told him that he could do nothing to relieve his slight disability of the limb, and that the affection was incurable. About three years since he consulted me, but I could add nothing to what had been already said, and could suggest no treatment.

In November, 1891, the patient consulted me for a fracture of the body of the left scapula. This resulted from a fall backward, as he was descending from the step of a railroad car, the scapula striking

the edge of a projecting board or plank. This fracture healed rapidly and well.

In June, 1892, in jumping from a street car while in motion, and while his hand grasped the railing, he experienced great pain just below the right shoulder, and felt that the arm was broken. He came directly to my office. On examination I detected crepitus, diagnosticated fracture of the anatomical neck of the humerus, and treated him for that injury. Union took place quickly, and full use of the limb was obtained. The only noticeable feature in this injury was the occurrence of slight pain referred to the outside of the humerus, about the lower portion of the upper third. There was at that time no enlargement of the bone at this locality.

On September 19, 1892, the patient again consulted me, stating that a "lump" had appeared on the outside of the humerus at its upper part. I examined the arm and found distinct cylindrical enlargement of the humerus, obviously a sarcoma of the bone, and I stated this to the patient, advising him to consent to the removal of the shoulder joint, if the diagnosis should be confirmed by a preliminary incision. At the patient's request, Drs. Packard and John Ashhurst saw the case in consultation, and they agreed with me in the propriety of immediate operation. From a careful examination of the patient's entire clinical history, there was no doubt in our mind that the case was one of osteitis deformans, first described by Paget, and which had been followed, as is so often the case, by the development of a malignant growth.

The operation was fixed for October 5, 1892, but at the preliminary shaving of the axilla, and preparation of the limb, or by the patient's lifting of the limb, fracture, which may fairly be regarded as spontaneous and non-traumatic, occurred, as was made evident at the time of the operation, done in the presence and with the assistance of Drs. Keen, Ashhurst, Packard, and others.

To prevent hæmorrhage, the long steel pins of Prof. Wyeth were inserted by Dr. Keen, the anterior one transfixing the anterior axillary fold in front of the vessels, penetrating the tendon of the pectoralis major muscle, and emerging near the end of the acromion.

The posterior needle pierced the deltoid and emerged just below the acromion. By carrying the needle, especially the anterior one, well upward, the constricting rubber band was placed so high as not to prevent the rotation of the humeral head, or to interfere materially with its disarticulation.

This patient suffered very slight loss of blood at the time of the operation, and received but little shock. He reacted promptly and perfectly, and for several days did well, the wound uniting throughout, On the night between the fifth and sixth day the temperature rose to 104.5°, and a copious eruption, similar to that of measles, appeared on the abdomen and chest, and eventually invaded the extremities, and indeed the whole body. There was marked coryza, and the tongue became brown and dry. This condition resisted all treatment and the free use of antipyretics. As the eruption spread, the temperature still rose, reaching 107.5° and 108°, and the patient died on the afternoon of the 15th day of October, the tenth day after the operation. The intellect remained clear until within an hour or so of the end.

I cannot but regard the death as due to some form of septic infection not easy to determine.

It is unnecessary to add that the antisepsis was observed in the treatment before, during, and after the operation.

The specimens, showing the sarcoma of the shaft of the humerus, and the peculiar indented fracture of its head and anatomical neck, are before this Academy. I particularly desire the observation of the Fellows to the fracture, which appears to me to have resulted from violent impact of an infiltrated diseased caput humeri against the edge of the glenoid cavity.

CASE II.—*Amputation at shoulder joint for enchondroma of humerus.*—The other case of shoulder amputation, in which I used Wyeth's pins, was that of a boy (I. B.), from Vermont, ten years of age. Nearly a year previously a tumor, apparently an enchondroma, began to develop on the inner side of the humerus, close to the head of the bone. It eventually grew until it attained a diameter of two and a half inches. It was painless, but interfered with the joint motion by its bulk. The boy was brought to the clinic of the Jefferson Hospital, and after consultation with my colleagues, I determined to remove the arm at the shoulder.

This was accordingly done on the 28th of November, Wyeth's pins being first introduced by my colleague, Prof. Keen. The anterior pin was made to emerge three-quarters of an inch above the tip of the acromion. As a result the circular turns of the tubing rested on a somewhat higher level than in the preceding case. Perfect freedom of the joint was preserved, and its disarticulation was not unimpeded. Previous section of the bone with the saw, as directed by Professor Wyeth, was not necessary. A roller bandage was applied as a compress under the tubing and directly over the artery. Hæmorrhage was thus perfectly prevented, and the removal of the limb, as in the former case, was practically a bloodless procedure. This boy recovered without accident.

I may state that in both these instances an Esmarch elastic bandage was applied previous to the insertion of the pins.

DISCUSSION.

DR. WILLIAM W. KEEN: I would call attention to the control of hæmorrhage by Wyeth's method. This afforded perfect hæmostasis. I never saw anything better, and as compared with the method which I devised myself a few years ago, by a compress over the subclavian artery, I think that it is vastly superior. In the first of Dr. Brinton's cases the pins were brought out at the end of the acromion process, and when the head of the bone was removed the skin slipped down and the constriction of the tube partially obliterated the cavity where the head of the bone had been. In the second case, the pins emerged three-fourths or an inch from the tip of the acromion, and there was no trouble from the slipping of the tube downward.

Dr. JOHN B. DEAVER: How much blood was lost in these cases?

Dr. BRINTON: In the first case there was a little blood lost on account of the slipping of the rubber tube—perhaps two ounces. In the second case there was practically no blood lost.

Dr. DEAVER: I have had no experience with the Wyeth pins in amputation at the shoulder joint. I have relied upon good assistance and have never seen much bleeding. There is no doubt that the method

described is an excellent one, and the only question in my mind was whether the presence of the tube did not interfere with the manipulation in disarticulating. In the few chronic cases on which I have operated all have recovered.

Dr. JAMES M. BARTON: Unless there is some tumor encroaching upon the joint, interfering with the manipulation, I am in favor of an assistant grasping the artery as the flap is divided. Some years ago I saw a case of large sarcoma of the head of the humerus perish from hæmorrhage on the table. The pins under such circumstances would have saved life.

Dr. W. W. KEEN: I think there is no possible doubt that the tube does not interfere with the manipulation, but that it assists us in making them. You have absolute confidence in your hæmostasis which you cannot have in any assistant whose arm or thumb is apt to get tired.

Dr. H. R. WHARTON: I have not had any experience with Wyeth's pins in shoulder joint amputation, but I can see how the method should be very useful, although I have not seen much bleeding where there have been good assistants. In my experience the most blood has been lost in the preliminary incisions. The only point would be in regard to the interference with the disarticulation if the tube slipped. I have seen Dr. Agnew use a pin under the vessels with a ligature above, which controlled the hæmorrhage very satisfactorily.

THE PRESIDENT: Some years ago I used the Esmarch tube in the shape of a figure eight in amputation at the shoulder joint with perfect success. An assistant held it up when there was any tendency to slip.

Enterectomy for Obstructive Epithelioma at the Ileo-Cæcal Valve; Secondary Anastamosis Operation by Abbe's Long Incision.

BY JAMES M. BARTON, A. M., M. D.

Surgeon to the Jefferson College Hospital and to the Philadelphia Hospital.

I saw Mr. B. for the first time, on April 18, 1892, at Millville, N. J., in consultation with Drs. Smith and Newell. He was in bed, was very pale and thin, and had frequent attacks of sharp pain while we were talking to him. I obtained the following history. He was twenty-seven years of age, and had been in his usual health until the first of January, when he had an attack, similar to the present one, lasting one week. From then until the latter part of March he was able to attend to his work in the glass house, but was troubled with some pain and considerable tenesmus. He went to the water closet from four to eight times daily, passing, with difficulty, a few small scybala each time. His constipation increased until four weeks ago he had several attacks of complete obstruction, each lasting four or five days, and only relieved after taking many purgatives.

He now has and has had for the last two weeks about four diarrhœic passages daily. He has severe attacks of cramp in the right iliac fossa every few minutes, requiring the constant use of large doses of morphia. These attacks are accompanied by a half inch elevation of the abdominal walls over the painful point. As the pain leaves, the abdominal wall descends, and gurgling of wind is heard and felt. He has been confined to his bed for two weeks and is greatly exhausted. There is no elevation of temperature, no tenderness on pressure, and there is no tumor felt, though carefully search for. There has been no vomiting at any time.

From the absence of vomiting and the marked tenesmus present, I regarded the obstruction as being in or near to the beginning of the large bowel; that it was not far from the ileo-cæcal valve was shown by the elevation of the abdominal wall at this point by the obstructed gas. The diarrhœa was an evidence of an intussusception, and the very short time the symptoms had existed, and the very complete obstruction present, pointed to a malignant growth as the cause of the intussusception.

Two days later I again visited Millville for the purpose of removing the growth. I was assisted by Drs. Newell and Smith, of Millville, Dr. Jones, of Camden, and Mr. Borsch, a student at Jefferson College. An incision about three inches long was made in the right iliac fossa, similar to the incision made in removing the appendix. On introducing the finger the growth was found at once. The intussusception could not be reduced, as the epithelioma had grown since it had occurred. After incising the bowel to verify the diagnosis, I removed about six inches of the intestine, including the obstructing epithelioma. Preparations had been made to perform lateral anastamosis at once, but the patient was so severely shocked that the operation was terminated by a temporary artificial anus.

He recovered without difficulty, rapidly gaining flesh and strength, and came to me, in Philadelphia, in June, to have the anastamosis operation performed. I placed him in a private room in the Jefferson College Hospital, and on the 16th I operated, assisted by Drs. Ashton, Fisher, Mr. Borsch, and the house staff. My purpose was to make a long opening, by the method devised by Dr. Abbé, between the lowest possible portion of the ileum and the highest and most convenient portion of the colon; to permit the artificial anus to remain as a safety valve and only close it after the anastamosis opening worked satisfactorily. In order to determine where to make my incision, I probed the bowel at the artificial anus, some days before the operation, with various sounds and catheters, and found it ran directly across the abdomen to the left iliac fossa. As I could not hope to join this to the ascending colon, I decided to use either the transverse colon or the sigmoid flexure, and to open the abdomen by a short incision to the left of the left rectus, as being within reach of both these portions of the large bowel and directly over the portion of the small bowel I wished to use but far enough from the artificial anus to escape the risk of infection. This was an error, the incision should have been made in the median line, rather higher than I did make it and long enough to get a fair view of the intestines.

Just before opening the abdomen I introduced a sound into the artificial anus, so that I might be able to verify, without delay, the portion of the ileum I wished to use after the abdomen was opened.

A three inch incision was made about two inches to the left of the median line and parallel with it, ending just above Poupart's ligament. The ileum, with the bougie in it, was readily identified, and as the transverse colon hung well into the wound, the sigmoid flexure was not searched for. After stripping

the portions of the bowel I intended to use of their contents, and preventing their return by a temporary rubber ligature, the ileum and colon were laid side by side and joined by a line of suture five inches long; when completed the needle was removed and the unused thread permitted to remain. A second line of suture, four and a half inches long, parallel and close to the first was introduced, and the unused threads were also permitted to remain.

Both bowels were then opened by a four-incision about a quarter of an inch from the last suture. A third suture was used to join the edges together, passing each stitch across the freshly divided edges so as to check the bleeding. This stitch is known among seamstresses as a "whipping stitch." The pliability of the intestines is such that not only the distal edge can be so closed, but a large portion of the edge on the side of the incision toward the operator. A needle was now placed on the unused thread attached to the second line of suture, and this was continued around the ends and in front of the opening, joining the intestines together at about a quarter of an inch from the opening and parallel to it. This suture, when completed, entirely surrounds the opening, and is about a quarter of an inch from it. Lastly, the unused thread of the first suture, which was still hanging at the end, has a needle put on it, and it is carried around the ends and in front of the opening. This suture when completed also surrounds the opening and is about half an inch from it.

The operation can be quite rapidly performed, the intestines being held in contact, by an assistant. After the first line of stitching is made it is still easier, and the suture can be made nearly as fast as the same operator would sew a seam in muslin.

The whole operation was performed with a constant stream of tepid boiled water flowing over the intestines we were joining together. As soon as the stitching was completed the intestines were replaced in the abdominal cavity, which was thoroughly flushed, and as the sutured intestines laid in position without undue strain, the abdomen was closed.

The slight vomiting after the ether soon ceased. A number of ounces of fecal matter passed from the artificial anus, but less than before the operation. At the expiration of twenty-four hours there was occasional regurgitation of fluid from the stomach and when I saw him at 8 o'clock on the second morning, the regurgitated fluids had become coffee-colored. An hour later, forty-three hours after the last operation, I reopened the wound, but failed to find the cause of the obstruction. The sutured intestines laid quite stiffly in place, being kept so by the numerous lines of sutures and the resulting plastic deposit, the small intestine was rather sharply flexed at the extremity, but not enough to obstruct. After as full a search as the condition of the patient warranted, it was concluded that the obstruction must be at the sutured portion. A loop of the ilium above the anastomosis was therefore drawn into the wound and another artificial anus made, but the obstruction was unrelieved, neither gas nor fecal matter passed, and the patient died forty-eight hours later, or four days after the operation.

At the post-mortem there was no evidence of recent peritonitis anywhere, the cause of all the difficulty being an old adhesion of the ilium to the abdominal wall at the left iliac fossa. Trailing the ilium up from the original artificial anus in the right iliac fossa, it ran directly across the abdomen to the point of attachment in the left iliac fossa, making a tense band; it then ran downward, and six feet were in the pelvis. I had drawn about two feet of these six under the band and used them for the anastomosis operation. The remaining four feet, still in the pelvis, were sloughing, its circulation being entirely shut off by the band. All the parts above the band, including the intestines used in the anastomosis operation, were in admirable condition. The immediate cause of the obstruction was the increased tension of the band, produced by pulling another loop of intestine under it at the operation. This band would probably have given trouble even if the anastomosis operation had not been performed.

The result in this case has not made me feel dissatisfied with the operation. I still think that it is the only tried method of obtaining a sufficiently large opening between intestines. Any smaller opening, no matter how made or with what devices, will be apt to contract and obstruct.

The Abbé operation can be quite rapidly performed. In the case above narrated, the patient suffered from no appreciable shock, though he had but recently recovered from a nearly fatal illness.

In performing this operation again I should make the incision in the median line, and make it higher and longer, so that I might not only see the condition of the intestines, find any abnormal adhesions, but before joining the intestines I should place them in position in the abdominal cavity so that they might lie without strain or tension. The intestines when joined by six lines of sutures are as unyielding as if there were a piece of card-board between them five inches long. If the intestine does not lie easily in its new position, the bowel at one end or the other of the stiffened portion may be so sharply flexed upon itself as to cause obstruction. In addition, from the same cause, there may be unnecessary strain upon the sutures.

The sutures in the above case were severely tested, the transverse colon was pulled upward by the gastro-coelic omentum, while the ilium, a few inches below the suture, was fast anchored by the adhesion. This strain was greatly increased by the subsequent abdominal distention and frequent vomiting. But as the specimen, which I here exhibit, shows, it held perfectly.

The specimen removed at the enterectomy shows almost complete obstruction, the opening that remains being less than a quarter of an inch in diameter.

DISCUSSION.

DR. W. W. KEEN: The question of contraction again comes up. I have a patient on whom I did a gastro-enterostomy a year ago, making an opening only an inch and a half in length. He is still perfectly comfortable. But in spite of such a result in a single case I believe that the long incision advocated by Abbé is the right one.

Mr. Treves has a brief article in a recent issue of the *Lancet*, reporting a case in which he removed a portion of the sigmoid and brought the bowel together end to end in a very simple way. He first sewed the mucous membrane of one end to that of the other all around, and then inverted the peritoneum with a simple Lembert suture. The operation was done in a comparatively short time and the patient recovered beautifully.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Dr. Franklin H. Martin.

The subject of this sketch, Dr. Franklin H. Martin' was born in Oconomowoc, Wis., July 13th, 1857. His education was received in various parts of the same State until 1877, when he came to Chicago and entered the Chicago Medical College. Upon the completion of his medical course, he obtained, by competitive examination, a position as interne in Mercy Hospital, where he served during the years of 1880 and 1881. Leaving the hospital, Dr. Martin decided to locate in Chicago, and immediately entered upon his professional career in that city.

Dr. Franklin H. Martin.

In 1884 he became much interested in the reports of Dr. Georges Apostoli, of Paris, concerning the use of electricity in fibroids of the uterus. Acting upon the principles laid down by Dr. Apostoli, Dr. Martin has, from that time to the present, worked most enthusiastically and successfully with electro-therapeutics, as applied to gynæcology and has probably done as much original work in this direction as any man in our country. He is one of the charter members of the Electro-Therapeutic Association and has always been keenly interested in the success of that organization. He is not, however, an enthusiast in electricity to the exclusion of all other means. In 1888 he was appointed to the staff of the Woman's Hospital, where he has won for himself the reputation of a skillful and successful operator.

As a teacher Dr. Martin was, in 1886, appointed to the chair of Gynæcology in the Chicago Policlinic. Two years later he withdrew from that institution and with Dr. W. Franklin Coleman, Henry P. Newman, Robert Babcock, founded the Chicago Post-Graduate Medical School, with which he is still connected, occupying at present the position of Secretary.

For a number of years he has been a regular attendant of the meetings of the American Medical Association, acting in 1892 as Secretary of the section of gynæcology. He is also a member of the American Gynæcological Association and connected with many of the local societies, most prominently perhaps with the Chicago Gynæcological Society, where he is actively interested.

Dr. Martin has, as a writer, for many years kept himself in touch with the profession by numerous articles published in various medical journals. Last fall, however, he ventured upon a broader field and brought out a volume, entitled "Electricity in the Diseases of Women," which is now in its second edition.

A CORRECTION.—In the announcement of the summer course of lectures at the Chicago Post-Graduate Medical School, by Lawson Tait, of Birmingham; Reginald Harrison, of London; Schauta, of Vienna; Price, of Philadelphia, etc., by an unfortunate mistake of the printer, Dr. Emory Lanphear is placed as a resident of New York, and his subject is not mentioned. The topics discussed by him will be embraced in the title: "Some Achievements in Intracranial Surgery;" and his remarks will be based almost entirely upon his personal experience, which in number and variety of cases is more extensive than that of any other American surgeon. Inasmuch as this work has been done in Kansas City, it is but just that this note of correction should be made.

A FACSIMILE.—The following is the facsimile of a note written by Dr. W. C. Wile, to *Daniel's Texas Medical Journal*, according to Daniel. Wile's opinion has not been made public.

DANBURY, CONN.,
De. 24, 1892.

Lim Saul:

Ipe eel exubub nite sissi ble ⌒◡ T z G. Monelz—Cohm *lu lu* che tree ale etc cobih 2. Of eye re—ie lb nomll os enfils *oo* I clo gr. duel! Cfu *nuece* c bun lun sleet buncombe z alce I t & m vin figillly ohu iley force grs. Io Tx—tonio r Ni 8 st coe PraeH. rocle.

W◡◡

ABSTRACTS.

Medicine.

DR. DUJARDIN-BEAUMETZ'S TREATMENT OF OBESITY.—"For the treatment of obesity in a person whose heart and arteries are sound," says the *Lancet's* Paris correspondent, "the above-named physician recommends the following method: Every morning a general body-sponging with hot eau de cologne and

water, followed by dry rubbing and massage. A tumblerful of purgative water is then administered. At the end of each meal a dessertspoonful of the following solution is swallowed: Fifteen grammes of iodide of potassium and 250 grammes of water. The undermentioned regimen is to be rigorously observed: First meal at 8 A. M., a cup of chocolate and 20 grammes of bread. Second meal, two eggs, or 100 grammes of meat; 100 grammes of green vegetables or salad; 15 grammes of cheese, a little fruit, 50 grammes of bread, a glass and a half of liquid (a light white wine with Vichy water.). Third meal at 7 P. M., no soup, 100 grammes of meat, 100 grammes of green vegetables or salad, 15 grammes of cheese, fruit, 50 grammes of bread, a glass and a half of liquid (white wine with Vichy water). No drinking between meals, no tea, coffee, cognac, or other alcoholic beverage. Plenty of exercise in the open air." —*N. Y. Med. Jour.*

A Method of Removing Tattooings.—In the *N. Y. Med. Jour.* Dr. Ohmann-Dumesnil reports good results from the following method which Dr. Dupuy claims originated with the natives of the Indian Archipelago: The tattooed part from which it is desirable to remove the markings is, first of all, carefully washed with soap and water. Then a bunch of needles previously prepared, containing from six to ten very fine cambric needles tightly wound with silk thread, is dipped in glycerole of papoid (Johnson and Johnson) and driven with a sharp blow into the tattooed part. This is repeated over the entire stain. In fact, it is a tattooing with the glycerole of papoid. It goes without saying that this tattooing must be thorough or but an imperfect result will be obtained, on account of the depth at which the pigment is found. I have found it necessary, as a general rule, to go over certain parts a second time in order to obtain a good effect. A peculiarity in reference to this is that the process does not bring about the swelling or inflammatory reaction observed in tattooing with India ink or other pigments. This is probably due to the fact that, in the first place, the glycerole of papoid is not so irritating; and, in the second place, no buccal mucus is mixed with it, a habit which is not only filthy but dangerous, inasmuch as it may transmit syphilis, as has been observed in many instances. Not only this, but the microörganisms of the mouth may act deleteriously by inducing septic conditions of greater or less virulence.

The rationale of the method is one which appears to me to be about as follows: The digestive principle of the papoid is disseminated about the deposit of pigment, thus liberating it. A portion is absorbed, in a finely divided state, by the lymphatics; another part probably finds its way into the upper layers of the epidermis and thence to the surface. In this manner we obtain a disappearance of the pigment. The glycerole of papoid is the only agent which I have found to act satisfactorily in this condition. I have tried solutions of papoid (Johnson and Johnson) made extemporaneously, and they did not procure good results, although the powdered papoid mitigated with some alkiline powder has acted very satisfactorily in old and indolent ulcers. Papain and papayotin made into solution have also proved complete failures in the treatment of tattoo marks in my hands, so that I would advise all who intend to use this method to confine themselves to glycerole of papoid as made by Messrs. Johnson and Johnson, of New York.

Tetanus Complicating Diphtheria.—Baginsky records the case of a boy, about five years old, who was admitted under his care for inability to open the jaws properly and for stiffness in his limbs, which had been present for four days. There was a difficulty in getting a view of the throat, and nothing beyond an alcer on the edge of the tongue, covered with a grayish pellicle, could be distinguished. There was marked trismus and recurring spasms of the muscles about the cervical region. Chloral hydrate administered *per rectum* had no effect, and the blood-serum treatment was carried out by Behring. This had some effect on the paroxysms. On the sixth day after admission the patient developed a rash closely resembling scarlet fever. It was still impossible to have a view of the pharynx. Next day the eruption was more marked, and a swelling appeared on the outside of the left kneejoint. On the eleventh day diphtherial ophthalmia set in; and an examination of the throat, now possible for the first time, showed redness without exudation, enlarged tonsils, and a slightly infiltrated uvula. By this time the tetanic attacks had gradually lessened, and only occasionally were severe contractions observed. After the arrival of this patient in the ward several other children developed genuine diphtheria, and there could be no doubt that the first had that disease along with tetanus, the source of the diphtherial process being the ulceration of the tongue and pharynx, although it was difficult to isolate the bacilli on account of the trismus present. Later on, the child suffered from well-marked paralysis of the palate, ocular muscles, and lower extremities. In this case the treatment by tetanic blood-serum as recommended by Behring had apparently some salutary effect upon the spasms. (*Berlin. Klin. Wochenschr Practitioner.*

Kneipp's Water Cure.—Dr. A. Schleicher describes the hydrotherapy practised by a priest named Kneipp in a small Bavarian village, where he has gained numerous adherents. Kneipp's system consists in certain hydrotherapeutic measures, the administration of simple household remedies, and the regulation of the patient's mode of living. To strengthen the nervous system, the patient is advised to walk on moist grass or in a bath tub filled up to his ankles with cold water. The cold pack, consisting of several thicknesses of coarse linen, is employed in certain cases, the sheet being wrapped around the entire body from neck to groin or applied to the abdomen or back; it should not remain longer than an hour. As regards the use of baths, the cold footbath should last from one to three minutes; the warm footbath has a temperature of 99° F., and lasts from ten to fifteen minutes, and is followed by a cold footbath of half a minute's duration. A half-bath is administered by letting the patient stand, kneel or sit in the water while the back and chest are washed; it should not last longer than three minutes. The sitz bath is taken before going to bed; its duration may vary from half a minute to three minutes. If taken warm, it may last for half an hour, and an infusion of herbs is usually added to the water. The full bath, according to Kneipp, is more effective the shorter its duration, and is mainly indicated in febrile conditions. The warm full bath has a temperature of 90° to 99° F.,

and consists of an infusion of pine needles. It is followed by cold affusion or washing of the body with cold water. Steam baths are carried out in a primitive manner, the steam being supplied by a kettle of boiling water. The cold affusion is made with a sprinkling can from which the sprinkler has been removed; the entire body or simply the affected parts may be acted upon; in weak persons the water should be tepid. Another favorite manner of applying water is to sponge the body or affected parts with a wet, coarse towel. This procedure is best done in the morning, and should not last more than two minutes.

Kneipp advises that the patient should drink whenever thirsty, but never large quantities of fluid at a time, and none during the meal. His materia medica consists of simple domestic remedies. He is opposed to excessive use of meats; does not interdict wine or beer in persons accustomed to their use, but thinks less favorably of coffee and tea. He urges an abundance of fresh air and exercise, and advocates coarse linen underwear in place of woollen garments.—*Zeitschrift für Therapie.*

Post-Mortem Discolorations.—There is no doubt whatever of the medico-legal importance of discolorations on cadavers, and of determining accurately their difference from ante mortem lesions. Dr. R. A. Pritchard states (*Am. Pract. News*) that it is not uncommon for a corpse to present lividities, or post-mortem discolorations, which are not true ecchymoses, or stains produced by the extravasations of blood before death. They are usually seen in dependent parts of the body, and must be distinguished from the true ecchymoses of bruises sustained during life. When clothing presses upon a dead body there develops vibices, or linear discolorations, as if the parts had been striped by the lash of a whip or switch. The post-mortem stains of the body that has lain in water, as one case especially I call to mind, are denominated suggillations. The stains exhibited on the dependent parts of the body laid out for burial are hypostases. The coloring matter of the blood is carried downward by gravity. I noticed after a short time an abundance of these in the thoracic region of a women crushed to death by a crowd panic stricken at an alarm of fire in a theater. Death occurred at three P. M., and the hypostases were marked the next morning. Extravasated blood was found inside the thorax. The outward discoloration was in part a sequence, I believe, of asphyxia. I have often seen it about the necks and chests of the asphyxiated.—*Med. Review.*

Diagnosis of Apoplexy.—Mills (*Polyclinic*) based the diagnosis of apoplexy on the following points:

1. The sudden fall, with unconsciousness at once, no injury perceptible, face white.
2. Respirations stertorous, noisy, puffing cheeks, tendency to Cheyne-Stokes, interrupted, improved by turning on side.
3. Right face droops more, and right cheek flaps more than the left. Right pupil widely dilated; left contracted. Retinal veins distended. No rotation of head and eyes to one side.
4. Pulse full and slow; temperature subnormal.
5. Convulsive movements noted at first have ceased; both arms and legs drop lifeless equally. Left side was paralyzed first. Sensation almost completely abolished.

The urine was albuminous and loaded with casts; there was aortic regurgitation, and a history of previous paresis and aphasia. The diagnosis was confirmed by the autopsy.

Significance of Indican.—As is well known indican, as such does not exist in the urine. It is produced by oxidizing indoxyl potassium sulphate itself derived from indole. In speaking of indican in the urine Dr. C. A. Herter says (N. Y. *Polyclinic*): Practically, therefore, the case stands this way: When we find indican in excess we know the case is one in which a certain kind of intestinal putrefaction is excessive, but when we fail to find indican we cannot be sure that we can exclude excessive intestinal putrefaction, though we may perhaps do so in some cases. Clinically, the following are among the most important conditions in which the excessive indican reaction is met:

1. Chronic intestinal dyspepsia, often associated with clay-colored stools, headaches and mental depression.
2. Neurasthenic conditions, generally with or without evident digestive disorders, and often dependent in males upon habitual sexual excess.
3. Habitual constipation, frequently, but not by any means constantly found.
4. In males immediately after sexual excess or masturbation.
5. In some cases of epilepsy, especially at the time of the seizures.
6. In children suffering from "night terror" or somnambulism; other evidences of digestive disorders are generally present in these cases.—*Med. Review.*

Itch of Cerebral Origin.—Dr. L. Breener ("Rev. of Insanity and Nerv. Dis.") arguing from Edinger's case of paralysis of the right arm and leg, accompanied by athetosis and by excruciating pain at all times, in whom was found a softened spot in the external nucleus of the left thalamus opticus, urges the theory that there may be pain of central origin. How else can be explained the pain of the hypochondriac or the hysterical, or that of hypnotic suggestion? The epileptic aura, which may be an itching instead of a pain, "is a projection of a cortical irritation on a corresponding area of the skin." Certain persons cannot hear vermin spoken of without being afflicted with a sensation of itching. This "is brought about by an association process in the hemispheres." He has often seen pruritus accompany melancholia, and reports two cases in which it preceded the mental trouble. The pruritus that is so frequently met with in hysteria and neurasthenia is, undoubtedly, a brain itch, and not a pheripheral one. He denounces the custom of gynæcologists of treating pruritus about the vaginal orifice in neurasthenic women. For treatment he combines bromide (10 to 12 grains) and cannabis Ind. ext. (¼ gr.), three times daily. He advocates a warm bath, with a handful of wash soda and a half pound of starch in an ordinary bathtubful of warm water. This simple measure has given better satisfaction than any other in institution treatment when such cases are notoriously often a source of despair to the physician and patient. Even in strictly central itch it generally acts well.—*Medical Standard.*

Therapeutic Effects of Suggestion in a Waking State.—Dr. Gibert, of Havre, publishes an account

of a case in which he made use of suggestion to a patient in a waking state with a therapeutic object. The patient was a boy, *æt.* 13, the backs of whose hands were so thickly covered with warts that he could not bend his fingers so as to hold a pen or even a knife and fork. The warts were crowded over the skin from the nails to the bend of the wrist. There were none on the palmar surfaces. M. Pierre Janet and several doctors were invited to observe what effect suggestion might have on this boy in a waking state. Dr. Gilbert took the boy by his two hands and stood face to face with him, gazing at him steadily, and said to him in a strong decided voice, "Do you want to get well?" At first the boy answered in low tones; but when the doctor had pressed the question upon him several times, he spoke up more confidently and said, "Yes, sir, I do." "Well then" said Dr. Gibert, "mind what I say. I shall wash you with blue water, and if you are not well in a week I shall wash you with yellow water. Here, Charles, bring me the blue water!" and thereupon he sponged the boy's hands with some water tinted a little with blue, and dried them carefully. On that day week, when they met again, the warts were all gone except two or three. Dr. Gibert spoke very seriously to the boy for not having got rid of them all, and proceeded to sponge his hands with yellow water, which the boy imagined to be scalding him. A few days later the skin was quite clear. This was an instance in Dr. Gibert's opinion of the influence of suggestion without hypnotism.—*Journal de Med., Practitioner.*

Constipation and its Treatment by Large Enemata of Oil.—Prof. Heiner, in an article in the *Beliner Medicinische Wochenschrift*, discusses this question, and recommends the large enemata of oil as the curative agent in such cases. He divided constipation into two classes, the "atonic" and the "spastic." The first he considered to be the result of insufficient and slow peristalsis, but the latter he considered to be due to spastic contraction of the colon. This condition he considered most frequently found in nervous persons, neurasthenics, hypochondriacs, and women with pelvic troubles. Firm masses of fæces are kept back by sections of intestine that remain in a state of firm contraction, and hinder the onward movement of the fæces. The evacuations in such cases are characteristic. They are thin, of small caliber, and of moderate quantity. Sometimes the fæcal matter is small and knobbed. He considered massage in spastic constipation as useless, and he also considered faradization and drastic purgatives as equally useless. For such cases he advised, as the best treatment, a large enemata of oil. With the patient in the dorsal position, twelve to fifteen ounces of oil is injected. The pelvis should be raised as high as convenient; the oil should be warmed and emptied into the bowel. The administration should occupy about fifteen minutes. The enemata should be repeated daily until a favorable result is obtained. After this a smaller quantity of oil will be sufficient.

Sometimes the oil produces an irritation of the sphincter. If the best olive oil is used, however, this is not likely to occur. The oil is supposed to act by softening and loosening fæcal masses, by soothing and diminishing irritation, by exciting peristaltic action, by preventing reabsorption of fæcal constituents and all their decomposition products.—*Canad. Pract.*

Surgery.

Syphilis of the Larynx.—In a clinical lecture on syphilis of the larynx Dr. Felix Semon stated that the manifestations of the disease are of a three-fold nature, belonging either to the so-called secondary or to the tertiary stages; or, thirdly, being of congenial origin. The manifestations appear in the following forms—simple catarrh (Lewin's erythema), papules (condylomata, mucous patches); diffuse infiltration, gummata, ulcerations, fibroid metamorphosis, cicatrices (membranous adhesions, etc.,) neoplasms, perichondrits (sometimes leading to ankylosis of the crico-arytænoid articulations, and paralyses. Of these the first two are most frequently met with in the earlier or so-called "secondary" stages; most of the others belong to the group of "tertiary" phenomena. "Ulcerations" are common, though in very different degrees, to all periods of laryngeal syphilis; and, finally, all these manifestations may occur in the congenital form. No age is actually exempt. Both sexes appear to be affected, and in about equal proportions. Some of the most severe cases occur in those who use their voice professionally. The subjective symptoms depend either on the localisation or on the intensity of the syphiliticmanifestations. Dr. Semon treated of the objective symptoms in discussing the various forms. The inherited form shows itself either shortly after birth or about the time of puberty. Dr. Semon entered on the subject of differential diagnosis, treating specially of tuberculosis and malignant disease, and taking up the several points of distinction—color, rate of development of the ulceration, size, depth and limitation of the ulcers. In treatment Dr. Semon said that one ought to be guided in every case by its particular exigencies. The mercurial treatment which he follows is that recommended by Zeissl, which is as follows: Twenty grains of mercurial ointment are daily rubbed into various parts of the body. On the first day the ointment is applied to the skin of the neck over the larynx, on the second day to the inner surfaces of both upper arms; on the third day to the inner surfaces of both thighs; on the fourth day to the inner surfaces of both forearms; on the fifth day to the inner surfaces of both calves; on the sixth day to the skin over both loins; and on the seventh day to the skin of the back. This series is to be repeated for five times according to the exigencies of the case, each series being preceded and followed by a warm bath, and astringent gargles being used during the whole time.—*The Clinical Journal Practitioner 1893.*

Epistaxis.—Undoubtedly plugging the nares by aid of Bellocq's cannula, says Dr. Philips, is an excellent method, but occasionally, especially in country practice, a Bellocq's cannula is not at hand, and some method easy, effectual and effected by material always within reach, must be resorted to. Such a method I have found in the following: A piece of old, soft thin cotton or silk, or oiled silk, about six inches square(a piece of an old handkerchief will answer) is taken, and, by means of a probe, metal thermometer case, pen-holder, or anything handy, is pushed center first, "umbrella fashion," into the nostril, the direction of pressure when the patient is sitting erect being backward and slightly downward. It is pushed on in this fashion until it is felt that the point of the "umbrella" is well into the cavity of the naso-

pharynx. The thermometer case or probe, or whatever has been employed, is now pushed on in an upward direction and then toward the sides, so as to pull more of the "umbrella" into the naso-pharynx. The thermometer case is now withdrawn. We have now a sac lying in the nares, its closed end protruding well into the pharynx behind, and its open end protruding at the anterior opening of the nares. If it be thought necessary, and is convenient, the inside of the sac may be brushed with some household astringent, such as alum solution, turpentine, etc. A considerable quantity of cotton wool is now, by means of the thermometer case, pushed well back to the bottom of the sac. Then the thermometer case being held firmly against the packed wool, the mouth of the sac is pulled upon, and thus its bottom with the wool packed in it is pulled forward, and forms a firm, hard plug wedged in into the posterior nares. We may now pack the sac full of cotton wool dry or soaked in some astringent solution. The mouth of the sac may now be closed by trying it just outside the nostril with a piece of strong thread; it is then trimmed with scissors and the ends of the thread secured outside.

The above method is easier than any I know when both nostrils have to be plugged. It might be suggested to oil the cotton or silk in order to render its introduction easy and to prevent it adhering to the mucous membrane, and to render it easy of removal; but I have never found any difficulty without the oil, as the blood renders the material wet and easy of introduction, while the oil does not facilitate removal, and may modify the effect of the astringents that may be used. The plug may remain *in situ* as long as any other nose plug. In removing the plug open the mouth of the sac, and with small dressing forceps remove the cotton wool bit by bit; if there is bleeding, simply syringe the sac with weak carbolic lotion or Condy's fluid and repack with clean cotton wool, or wool impregnated with some antiseptic. If there is no bleeding when the wool is picked out, gently pull out the sac; or if it be adhering to the mucous membrane, syringe in a little warm water, and it may then easily be removed. This method has many advantages. (*a.*) It is easy, quickly accomplished, and effectual, and the materials are to be found in every house, and indeed, about everybody's person (I have plugged in this manner, simply using a handkerchief, one part of which was used for the sac, and the other torn into narrow strips in place of the cotton wool.) (*b.*) No damage is done to the floor of the nose or back of the soft plate by strings, etc.; (*c.*) no disagreeable hawking, coughing or vomiting takes place while the plug is introduced; (*d.*) there are no disagreeable strings left hanging down the throat, causing coughing or sickness while the plug is in; (*e.*) the plug can be removed gently without any force, so that no damage is done to the mucous membrane and no return of hæmorrhage caused. I employed this method frequently when in country practice, and do so now in bleeding after operation on the nares, and have always found it to be satisfactory. As the method has been of great use to me, and as I am not aware that anyone has spoken of it before, I take the opportunity of mentioning it, in the hope that it may be of some use to some brother practitioner when confronted by an urgent case of epistaxis, and other means of plugging are not at hand.—*Med. and Surg. Reporter.*

TREATMENT OF COMPOUND FRACTURES.—The views held by prominent surgeons upon this subject have always special interest for the general practitioner, whether he is located in town or country.

Tréves (*Annals of Surgery*) expresses a preference for the following as a treatment for this class of fractures.

On admission the limb is covered with lint soaked in carbolic lotion, and is then cleaned with the greatest care; protruding bone is removed, and the broken ends are adjusted as soon as possible.

1. Ordinary well padded wooden splints are used, but under no circumstances is the limb secured to them by strapping. Instead of plaster he uses fine webbing and buckles. No bandages are ever applied. 2. The limb is kept throughout in the open air. 3. The wound itself is covered by a heap of antiseptic powder—iodoform or creolin, preferably the latter. This covering of powder keeps out bacteria without hindering the free escape of discharges, which form with the protecting powders a harmless scab or crust. The advantages claimed are: 1. Simplicity. 2. Avoidance of "meddling." 3. The damaged part is open to view.—*British Medical Journal.—Canad. Pract.*

Therapeutics.

SALOL IN THE TREATMENT OF DIABETES.—Nicolair (*Therap. Monatsh.*, March 1893.; *Rev. gen. de clinique et de Therapeutique*, April 26, 1893) recommends thirty-grain doses of salol, three times a day, as a palliative in diabetes mellitus when it is impracticable to enforce an antidiabetic diet. In the course of a week, in favorable cases, the amount of urine passed becomes normal, also the proportion of urea, and the sugar and acetone disappear completely. In severe cases the action of the drug is less decided, but is still perceptible. The symptoms recur when its use is discontinued. Sometimes it causes pain in the stomach, tinnitus aurium, and vertigo, and in one instance the author observed slight albuminuria.—*N. Y. Med. Jour.*

THE IODINE TREATMENT OF GOITRE.—Dr. E. Nazaries, *Bulletin de la Societe de pharmacie de Bordeaux*, Feb., 1893; *American Journal of Pharmacy*, May, 1893), remarks that, while iodine has long been used in the treatment of goitre, he has met with unquaified success by a particular method of its use. He dissolves from 75 to 90 grains of potassium iodide, and from 20 to 30 drops of tincture of iodine in about 5 ounces of distilled water. A spoonful (whether teaspoonful or tablespoonful, not stated) of this solution is diluted with a pint of water, and this amount taken daily, during and after meals. The author insists on the continued internal use of the drug.—*N. Y. Med. Jour.*

CODEINE AS A COUGH SEDATIVE AND ANODYNE IN PULMONARY AFFECTIONS.—At Prof. Jacobsohn's clinic, Berlin, the therapeutic value of codeine was thoroughly studied on about 400 patients who took in all some 5,000 doses of the drug. My observations may be summarized in the statement that codeine is a narcotic analogous in action with morphine, but less intensive, and free from injurious by-effects.

Truly brilliant results have been obtained from codeine in pulmonary affections. Our observations em-

braced mostly cases of phthisis. In view of the usual poorly satisfactory results of phthisis treatments, it is no mean consolation to be in possession of a remedy which is capable at least of making the oft sad condition of the phthisical somewhat tolerable.

Such a remedy we have in codeine, with the aid of which the sense of oppression in the chest, the stitch pains in the sides, the dyspnœa, and, first of all, the oft painful cough, can be efficaciously combated for any length of time.

In confirmation of Dr. Fischer's statements, I may with confidence say that since I have employed codeine I have been able to entirely dispense with morphine in most of my phthisical cases.

The some indications for a narcotic that present themselves in phthisis, of course more or less frequently exist also in other diseases of the respiratory tract—such as exacerbating bronchial catarrh, pleuritis and pneumonias. In such cases I have also largely employed codeine with good results. The same is true also of pulmonary asthma.

As regards dosage, two and one-half to five centigrammes (⅜ to ¾ grain) were given, three, four or five times a day, according to the case. It was seldom necessary to go beyond five centigrammes; when this dose had no effect, a larger one usually also failed. On the other hand, the dose which was once found to be efficient was always so, even when repeated frequently.

The remedy was generally given as a powder, inclosed in a wafer, or in a mixture sweetened with syrup (1:5); in a few instances it was administered in suppositories.—*Deutsche Medicinische Wochenschrift*, 1890, No. 20.—*Merck's Bull.*

TREATMENT OF DIPHTHERIA.—Drs. I. N. Love (*Medical Mirror*) and R. C. Atkinson have found that when the diphtheritic membrane is full-fledged or just developing, no better application for its dissolution can be made than the dried powder of papoid, applied by a camel hair-brush, moistened, thus taking up a liberal quantity, and applied directly or applied by insufflation. Repeated experiments with papoid applied to the membrane *in situ* resulted in its rapid softening, and a demonstration can be made of its value by taking a portion of the membrane, if separated from the mucous surface and covering it with papoid. It will melt as does the snow under the morning sun.—*Medical Standard.*

TROPACOCAINE AS A LOCAL ANÆSTHETIC.—Dr. Hugenschmidt (*La Semaine Medical*, Feb. 3, 1893), confirms the results of Chadbourne's experiments with tropacocaine. The ingestion of one-third or two-thirds of a grain produced no appreciable effect on an adult. When two-thirds of a grain were injected rapidly into the region of the lower maxilla, vertigo, uneasiness about the heart, and a marked fall of blood pressure were observed within three minutes. The effect was transient, and in ten minutes the pulse returned to normal. Doses of one-third to two-thirds of a grain do not affect respiration, whereas it is easily affected by full doses of cocaine. The above doses produce no effeet on the nervous system, whereas similar doses of cocaine often produce marked symptoms of cerebral anæmia. Tropacocaine exerts no influence on the vaso-motor system. Dr. Hugenschmidt believes that tropacocaine is likely to prove of great value as a local anæsthetic. He employed it as such in thirty-seven cases, never exceeding five-twelfths of a grain, usually in the following solution:

℞. Tropacocaine.....gr. ij.
Distilled water..... ..... ʒj.
SIG—Ten minims for an injection.

It is of the greatest importance that the injection should be made slowly. One-third of a grain was found sufficient to produce anæsthesia when the injection occupied fully one minute. With this dose no toxic symptoms were observed in the thirty-seven cases.

Dr. Hugenschmidt claims for tropacocaine the following advantages over cocaine:

1. Being prepared synthetically, it is less liable to variation than cocaine which is obtained directly from the plant.

2. In equal doses, consistent with the production of anæsthesia, tropacocaine is less toxic than cocaine, and exerts very little influence on the vital functions of the organism.

3. Local anæsthesia is produced more rapidly with tropacocaine, and lasts the same time as that produced by cocaine.

4. Tropacocaine being antiseptic, its solution can can be kept unaltered for months, whereas solutions of cocaine have a tendency to undergo decomposition and lose their analgesic properties after four or five days.—*University Medical Magazine.*

NITRO-GLYCERINE.—In certain conditions the action of nitro-glycerine or glonoin is marvelous. When a powerful stimulant is indicated, its universality of action distinguishes it from all others; and if given more freely than is necessary for the exertion of its influence in this way, it not only operates on the brain especially, but does so with great energy. In favor of nitro-glycerine is its smallness of bulk; and as an anti-spasmodic and nervous stimulant, it has no peer among medicines of that class. In a case of emergency, one drop of a one per cent solution may be placed on the tongue or inside the upper lip when the patient is in an unconscious condition. Its effects are immediately observed, by its property of relieving spasm, which it certainly does to a remarkable degree. Its effects are immediately manifested by the capillaries carrying more blood than they had done before its administration; the radial pulsation grows fuller, freer, and more rapid; and there appears an increased warmth of the extremities. An overdose of it produces giddiness, weakened vision, headache with throbbing in the temples, a sense of weariness, sleepiness and severe pain in the cardiac region, the usual trembling. Since the introduction of nitro-glycerine in therapeutics, I have not had an opportunity of testing its virtues in puerperal eclampsia; although my observations of its *modus operandi* as a nervous stimulant and a remedy in some other affections, especially those of a spasmodic character, have been quite satisfactory.—*Times and Register.*

PIPERAZINE IN THE TREATMENT OF STONE IN THE KIDNEY.—Dr. David D. Stewart, in *Therapeutic Gazette*, reports three cases in his usually careful manner. The urate of piperazine, which is said to be a neutral salt is seven times more soluble than is the corresponding salt of lithium. Despite the affinity of this remedy for uric acid, and the extreme solubility of its urate, little can be expected from it in uratic

chronic multiple arthritic enlargements, at least in the doses generally administered—fifteen grains daily. In much larger amounts, such as a drachm or two daily, exhibited over a continuous time, more promising results may be anticipated; whether, however, such doses will be tolerated without injury is yet to be determined. The present unfortunately high price of the drug prevents the determination of the question. In the first case, gravel, which had been a persistent and troublesome symptom for months, permanently disappeared. In the second case, which was one of undoubted pyelitis, the pus has almost entirely disappearee from the urine, being only ascertained by microscopic examination. In the third case that of probable mulberry calculus, no benefit has been obtained—which fact is in accordance with what might be anticipated from the behavior of this remedy with this salt of calcium, upon which it has no solvent action. The precise mode of action of piperazine is still obscure, although it is certain that it is beneficial in cases of gravel and stone.—*American Journal of the Medical Sciences.*

Diseases of Children.

GONORRHŒAL INFECTION OF THE MUCOUS MEMBRANE OF THE MOUTH IN NEW-BORN INFANTS.—From the study of five cases of gonorrhœal infection of the mouth in the *Konigsberg Obstetrical Clinic*, Dr. Rosinsky has drawn the following picture of the disease: Without preceding inflammatory redness, a white discoloration appears upon the anterior two-thirds of the tongue, the tongue, the plaques of Bednar, the hamulus pterygoideus, aud along the ligamentum pterygomandibularum in the lower jaw, finally upon the front parts of the gums. After twenty-four to thirty-six hours the color becomes yellow. The patches elevate themselves plateau-like over the surrounding tissues, and their surfaces are raw. The superficial epithelium forms with extravasated pus cells, a thick layer, resembling the scrapings from the cut surface of a septic spleen. On the third day the regeneration of the epithelium begins; this is marked by an inflammatory redness around the edge of the patch. Healing follows without treatment, in an ideal manner, no trace of scar or discoloration remaining. From the microscopical examination of some excised tissue, Rosinsky has gleaned the following: The gonococci were never found, in stained sections, intra-cellular. They were seldom found intra-cellular in the superficial flakes. Gonococci cannot penetrate into the body of healthy, living cells; they accomplish this only when the single cells are cut off from the conditions of life. In the connective tissue gonococci invasion was found. Rosinsky believes this to be typical pure gonorrhœal inflammation of the mucous membrane. The relatively infrequent gonorrhœal inflammation of the mucous membrane of the mouth in adults, in contradistinction to infants, he believes to be due to the tenderness of the epithelium of the mouth in the new-born.—*Annals of Gynæcology.*

A COMPARATIVE STUDY OF 690 CASES OF TRACHEOTOMY AND INTUBATION IN DIPHTHERIA.—Taking the cases treated in the Children's Hospital at Zürich between the years 1874 and 1891, Baer (*Deut. Zeitschr. für Chir.*, Band xxxv, Heft. 3 und 4, December, 1892) makes a critical and comparative study of the methods and results obtained. The mortality was 438 per cent in the 690 cases. According to whether tracheotomy or intubation were performed, in the years 1874 to 1888 and 1888 to 1891, the mortality was respectively 45.3 per cent and 39 per cent. But in the latter period there were a greater number of pharyngo-laryngeal cases, and since the mortality is greater in these cases, the actual mortality during the intubation period was 8 per cent better.

These better average results the author believes to be due not to the earlier operation, but to the form of operation itself, and especially in patients of the earliest years. Sex apparently has no effect either as regards prognosis or the course of the disease after operation. The author believes that the intubation method is not a rival of the treatment by tracheotomy, but a resource of less danger and more easily agreed to by the parents of the patient, while he reserves tracheotomy for the last resort, oftentimes indeed following intubation, but in special cases preceding it, and being the only method. His conclusions, arrived at after the experience and results shown by 690 reported cases, he sums up as follows, giving as his indications and contraindications for the use of tracheotomy: (1) There are not as many contraindications as have been formerly insisted upon, his statistics showing that the spread of the disease into the trachea is not a contraindication; (2) Feeble children should have intubation, as their chances are lessened by wound complications; (3) Cases in which death is impending require tracheotomy or intubation with short tubes; (4) When superior tracheotomy cannot be performed, it is preferable to use intubation on account of its shorter duration. He considers these as the indications for secondary tracheotomy following after intubation: (1) In cases which occur very seldom, where masses of loose or floating membrane prevent respiration even after laryngeal aspiration; (2) When laryngeal and tracheal stenosis persist after intubation has been performed; (3) Where coughing up of the tube occasions a threatened asphyxia. His indications for a primary tracheotomy and contraindications for intubation are: (1) Complete closure of the naso-pharyngeal space through swelling and the extensive formation of membranous deposits on the mucous membrane of the pharynx and tonsils; (2) Intense œdema of the glottis; (3) Complication by the presence of a retro-pharyngeal abscess; (4) In cases where the short tube cannot be used.

He also recommends intubation for cases of chronic stenosis after injuries, burns, etc., reporting two successful cases of this treatment.—*Annals of Gyn. and Pæd.*

TONSILOTOMY AS A PREVENTATIVE OF DIPHTHERIA.—Lancey, writing in the *Journal des Sciences Medical de Lille*, attributes the predisposition of children in some families to contract diphtheria and croup to the presence of hypertrophy of the tonsils. He has frequently observed the coincidence of enlarged tonsils in adults as well as in children with a liability to infectious "sore throat" and diphtheria. In a very large proportion of his cases of tonsilotomy, the enlargement was hereditary. Almost all the spasmodic cases of diphtheria which he has seen have been in children whose tonsils were enlarged. The indication is, therefore, in his opinion, to remove enlarged

tonsils in children if any other child in the family has suffered from diphtheria. Before the operation is done, some weeks should be allowed to elapse after exposure to infection, to allow time for the destruction of any germs that may have found their way into the child's throat.—*British Medical Journal; International Medical Magazine.*

TETANY IN CHILDREN.—Loos has written an article on tetany in children, in which he gives laryngismus stridulus as the most important symptom in the disease; the following are in conclusion:

(1) Tetany is a frequent disease of early childhood, and has well-recognized symptoms.

(2) It begins relatively seldom with spontaneous tonic contractures of the extremeties.

(3) Its presence is proven by the diagnostic sign of spasm of the larynx.

(4) It is not definitely settled whether spasm of the larynx alone is sufficient to establish a diagnosis of tetany.

(5) The symptoms of the disease are explained by the unusual excitability of the peripheral nerves and muscles.

(6) The excitability is caused by different irritants.

(7) The reason for this excitability is not known.

(8) The disease is more frequent in certain months of the year (spring).

(9) Tetany has no causal relation to rachitis.—*Med. and Surg. Reporter.*

SCARLET FEVER.—Dr. Wilson has employed chloral throughout the entire attack with asserted good results in the following manner; so soon as the patient is suspected or known to be developing scarlatina, a laxative dose of calomel, proportionate to the age and general condition is administered. Shortly thereafter chloral is given in moderate doses, at intervals of two or three hours, or longer, throughout the attack. The dose varies with the age of the child; the frequency of its administration depends largely upon its effect. To infants of two or three years a dose of from one to two grains may be given, the dosage being gradually increased with older children; that for adolescents reaching five grains. The tranquilizing and sleep-producing effects of the drug are, in most instances, promptly realized, the patient falling into a condition of quietude instead of the restlessness and jactitation which are so distressing in the well-developed disease.—*Hare's Therapeutics.*

Diseases of Women.

MOVABLE KIDNEYS.—J. Schmidt, M. D. (*Medical Record*), maintains that at least one woman in ten is afflicted with displaced or movable kidney, usually the right. The kidney may be palpated by placing the woman on her back with knees flexed, then with one hand beneath the free border of the ribs and making counter pressure with the other posteriorly, the patient at the same time taking a deep inspiration, the lower border of the kidney can be felt, and if the organ is loose it can be held in this position, when the air is forced out of the lungs and the kidney would naturally go up again.—*Annals of Gyn. and Pæd.*

OBSERVATIONS ON THE THERAPEUTIC TREATMENT OF UTERINE FIBROIDS.—In the *Med. and Surg. Reporter*, Dr. Thos. W. Adams offers the following deductions as a result of his observations:

1. That whenever a woman has a myofibroma of the uterus she can be benefited either by operation or treatment.

2. That whenever a woman has a myofibro cystic tumor of the uterus there is only one method of cure and that must be operative.

3. That the elective method of palliation or cure in any given case of myofibroma must be governed by the condition of the patient and the condition and relations of the tumor present.

4. That the elective methods of treatment of myofibromata are palliative, medicinally curative, electricity, operative.

5. That certain cases of myo-fibromata can be and are benefited and rendered entirely inert by the use of properly selected therapeutic agents.

6. That the class of myo-fibromata which are benefited by the use of therapeutic agents are those in which the muscular tissue largely predominate.

7. That the class of myofibromata, in which the muscular tissue largely predominates, are reduced in size and rendered harmless by the use of salix niger and ergot. That this does not, however, cover every tumor of this class.

8. Finally, in certain cases, the use of therapeutic agents, if not curative, makes an operative interference safe and of more easy performance; locally by lessening engorgements and loosening adhesions by its contractile effects, and constitutionally by relieving symptoms and thus allowing the attainment of a better general condition.

Obstetrics.

REPREHENSIBLE, DEBATABLE AND NECESSARY ANTISEPTIC MIDWIFERY.—Henry S. Garrigues condemns the too free use of antiseptic applications before labor, and strongly insists on the dangers of corrosive sublimate vaginal and uterine injections prior to, and after, delivery. In one paper he reports twenty deaths following, or due to, the use of this drug in obstetric practice. Of well-directed antiseptic methods he speaks highly. In the Maternity Hospital, before the days of antiseptic midwifery, the mortality in 1884 from sepsis was 0.76 per cent which has been reduced so that in 1891 there were no deaths from this cause. The Sloane Maternity gives von Braun 1,000 deliveries with but one death from septicæmia.

Peppingsköld, of Helsingfors, had an average of 650 yearly deliveries, from 1884 to 1887, with a mortality of only 0.29 per cent. Mermann gave 700 cases with but one death; and van Braun 1004 cases with only two deaths. The routine practice of the Maternity Hospital is carried out by Dr. Garrigues. A one per cent solution of creolin is, however, used in place of the corrosive, and the use of the vaginal douche before delivery is commended. The question as to the use of ergot as a routine measure is left for the physician to decide in each individual case. After the birth of the child no injections are given in normal cases. The use of antiseptic covers over the presenting part and vulva is not necessary or indicated, save that it gives the hand a firmer hold on the part presenting. The occlusion bandage is of service; it gives a sense of support, and in the poorer classes it keeps the dirt and filth, which usually surround them, from

entering the vagina. Vaginal examinations, while they should not be too frequent, ought to be made as the indications point. The higher mortality rate in labor cases in private practice is undoubtedly due to the less care exercised in and around the lying-in chamber as regards the precautions taken toward an absolute aseptic condition of attendants, instruments and the various objects used about the woman. The writer believes that with "hospital care" in private practice the percentage of fatal cases would be markedly reduced.—*Annals of Gyn. and Pæd.*

Opthalmology.

Treatment of Pannus by Antipyrine.—Dr. E. Roullet has recently described in his thesis a new treatment for *pannus scrofulosus* by means of antipyrine applications. The idea of the treatment originated in Dr. Vignes (Paris), at whose clinic Dr. Roullet has had the opportunity of personally observing its effects.

The eye having been rendered anæsthetic with cocaine, a thin layer of antipyrine is deposited on the surface of the cornea with a brush or by means of an insufflator. In spite of the previous application of cocaine, the patient complains of a rather pronounced burning sensation, which is attended with a more or less abundant lachrymation. When after a little while this reaction subsides, the eyeball is gently massaged through the closed lids.

Antipyrine gives rise to inflammation of the conjunctiva, varying in intensity in different individuals, and in consequence from one to several days must be allowed to elapse between two applications.

Dr. Roullet states that under the influence of this treatment, which presents no risk whatever, the looped vessels present in pannus rapidly disappear. This is due, according to the author, to the hæmostatic properties of antipyrine. The remedy is dissolved in the tears and absorbed by the blood vessels of the cornea, giving rise to changes which results in their obliteration.

There are, however, certain contraindications to the use of antipyrine in case of pannus. Dr. Roullet is of opinion that it should not be employed in cases where the condition is associated with ulcerations of the cornea or with phlyctenular keratitis. It is also contraindicated when the affection consists only in a slight hyperplasia of the blood vessels such as occurs in parenchymatous keratitis, for the new vessels are here of service in removing the migratory cells from the cornea. It is only in cases where there is extensive proliferation of the blood vessels that the application antipyrine should be resorted to.—*Med. Weekly, Paris.—Texas Sanitarian.*

Toxicology.

The Danger of Using Carbolic Acid and Its Derivatives with Children.—A timely note of warning was given by Simon (*La Med. Moderne*, March 18, 1893), at the Hospital des Enfants-Malades, when he called attention to the ease with which children are poisoned by this acid and its derivatives. He does not, however, include all of them. The salicylate of bismuth and salol are the two best borne, and no case is reported of their poisonous action. The use of this acid in dressing of wounds is dangerous; this he illustrates by a case in which, after a large wound dressed with carbolic solutions and carbolized gauze, there appeared the following day nausea, vomiting, pallor and headache. Pus was suspected, but the examination of the urine, its black color, showed the source of trouble; there had been absorption from the dressings of carbolic acid. He warns especially against its use and that of chlorate of potassium in cases of diphtheria.—*Annals of Gyn. and Pæd.*

Methyl-Blue Poisoning.—In these days when the over-sanguine are attempting the treatment of cancerous disease with this drug, it is interesting to note a case of poisoning in a man treated for swelling of the thyroid and other ductless glands following malarial fever, reported by Joseph Drezeweicki, M. D. (*Medical Record*, N. Y.) The dose taken daily was three powders of 0.20 gram each. After the first dose the urine became greenish and from that to a perfect blue, pain in bowels, accompanied by intense desire to urinate, sudden sharp, cutting pains during and discharge of pure blood at the completion of the act. Action on the bowels not so marked. The desire to defecate came on with the action of the bladder. The stools, several daily, were accompanied by tenesmus, but with little pain. In all, the man took four of the 0.20 gram powders and four of 0.15 gram, with same quantity of opium. The treatment consisting of milk diet with vichy water and warm sitz baths.—*Annals of Gyn. and Pæd.*

A Case of Acute Codeine Intoxication.—Medvei (*Internationale klin. Rundschau*, 1892,. No. 36, p. 1457) has reported the case of a woman, forty-two years old, of profoundly neurotic tendencies, who took seven and one-half grains of codeine with suicidal intent. For a half hour the patient presented no unusual manifestations, unless perhaps for uncommon cheerfulness and mirth. At the end of this time, however, she complained of a sense of heat, of suffocation, of restlessness and of vertigo. Soon, mental excitement, itching and redness of the skin were superadded. The conjunctivæ were injected; pupils were full and reacted sluggishly to light. Saliva dribbled from the open mouth and the tongue was shaken with tremor. The muscles of the face and extremities twitched convulsively. The knee jerks were exaggerated, although there was no responce to pressure or pricking. The pulse was forty-six in the minute, full and hard. The contents of the stomach were evacuated by means of lukewarm water, copper sulphate and a stomach pump. The pulse subsequently rose to 116 and became feeble and soft. Mechanical irritability was now greatly increased. The deep reflexes were greatly exaggerated. The pupils were dilated to the utmost. The pulse grew weaker and cyanosis developed, so that artificial respiration and stimulation became necessary. After vigorous treatment, continued for several hours, the condition of the patient improved and the danger of a fatal issue was averted. On the following day the patient slept a good deal, but was easily aroused. A day later she complained of headache, of mental confusion, and of intense itching.—*The Alkaloid.*

Masturbation, according to Prof. Parvin, is of rare occurrence in the female sex, the percentage being only about three-tenths of one per cent, whilst among the male sex it is about three per cent.

MISCELLANEOUS.

Medical Events.

Chloroform discovered by Guthrie of New York, 1831.

Pasteur's experiments in the line of germ culture, 1870–90.

The first naval hospital founded on the ship Dreadnaught, 1821.

The first grand international medical congress held at Paris, 1867.

Morphia discovered in opium by Senturuer; claimed by others, 1803.

Dr. Richard Bright published his researches on diseases of the kidneys, 1836.

Miss Garrett licensed in London to practice, the first female licensed doctor, 1865.

Vaccination made compulsory in England in 1853; in Ireland and Scotland in 1863.

The Bellevue Hospital, New York, founded and opened, with 800 beds for patients, 1826.

Vaccination generally practiced all over Europe. Anti-vaccination societies begun in 1816.

The ophthalmoscope invented by Helmholz. Revolution in treatment of eye disease in 1851.

Farraday's discovery of inductive electricity opened a new era in the history of medical electricity, 1831.

Lectures on medical jurisprudence first delivered in America at Columbia College by Dr. Stringham, 804.—*Med. Bull.*

Dr. Albert Ritter von Chrzasczewski, of Sambos, Galicia, Austria, on November 28, 1892, writes: Bromidia is superior to all other hypnotics, and is free from all unpleasant effects.

QUININE PILL-MASS—A CATCH PRESCRIPTION.—Apotheker, St. Louis.—Here is a prescription handed ıe to be filled, by a young M. D. just back from a w months' stay in the old country. How would you it?

℞ Quinine sulphatis.....grs. xv.
Acidi sulphur, dil.....q. s.
Mix and divide into six pills.

Don't you think the young doctor had better go back to Germany again for another semester or two?

The prescription is all right, as you will find if you mix the ingredients in a hot porcelain capsule. Add about five minims of the acid, and in a short time you will have a beautiful mass. This very question was some years ago the occasion of the appointment of a pharmaceutical commission in either Austria or Germany, we forget which. A certain apothecary who had accidentally discovered the reaction had a physician friend to write the prescription and send it to his rivals around town, all of whom declared that the pills could not be put up without the use of other ingredients. Apothecary No. 1 thereupon put up the prescription, and was roundly denounced by the other apothecaries as a fraud. The matter got into the local journals and came to the attention of the authorities, who thereupon appointed a commission of three experts to investigate. The commission differed; one of these declared it was impossible to make the pills without the addition of other ingredients. Another thought it possible, but very difficult, while the third experimented a little and solved the matter. It is highly probable that your young doctor had read of the matter (as considerable litigation grew out of it) and gave you the prescription as a puzzle.—*Nat. Drug.*

Dr. H. S. Houghton says, in a recent number of the New York *Medical Journal*, that one must look upon the patient who had just passed through the third stage of labor as a sufferer of traumatism, has been wounded, and, therefore, her case belongs to the domains of surgery. As the first law of surgery is rest, so the lying-in period is a period of rest, so modified that the patient emerges from it a well and perfectly healthy woman. After the birth of the child, the mother must look forward to a period of six weeks of convalescence devoted solely not only to getting well, but to getting sound and strong. This period is divided into two weeks of absolute rest in bed, one week of alternate resting in bed and moving about the room; the fourth, in gaining the effects of fresh air and sunlight, and the last two in gradually resuming the household duties. By carrying out this plan, as given in detail in the paper, the writer says we may hope to do away with the too frequent evil consequences of childbirth.—*Medical and Surgical Reporter.*

A FORTY-TWO POUND LIVER.—Dr. John P. Hillegoss reports the following in the *Univ. Med. Maga*:

Rev. V., aged fifty-eight years, gave the following history: Father dead, age not known; mother living, aged seventy-eight years. His past history is somewhat interesting. Thirty years ago he was a successful minister of the gospel. Twenty-four years ago he stopped preaching and engaged in the cigar business. In this he failed, and afterward he organized a theatrical company. Subsequently he came to Philadelphia and served several years as a police officer. He finally organized a congregation in Philadelphia and preached six years. During this time one of his eyes became affected and he had it removed. The nature of this ocular trouble he did not know. About five years ago he noticed an increase in the size of his abdomen. He consulted Dr. D. Hayes Agnew, who pronounced it an enlargement of the the liver. His symptoms were loss of appetite, vomiting, chills, disturbed sleep, highly colored urine, pain in right side, emaciation. Under appropriate treatment he improved, and occasionally preached. The enlargement gradually extended from the epigastric region over the whole of the abdomen, and it was outlined as if there were three distinct tumors. A year before his death he became an invalid, lost flesh and was dyspeptic and nervous.

About six months before he died he again improved; his appetite was voracious. He ate ten to twelve eggs a day besides meat, cracked wheat and other food. The urine was normal in quantity and contained a slight trace of albumin.

He formerly lived in New York City and contracted malaria, which he thought gave rise to his trouble. He denied ever having had syphilis, and

there were no indications which would contradict his statement. His wife on several occasions complained of a throat trouble, and the spells seemed to be of a syphilitic nature.

Death finally took place, and a post-mortem examination was held, which showed the enlargement to have been due to his liver, which weighed forty-two pounds. I sent a portion to Dr. Formad for microscopic examination, and he diagnosed it to be a leukemic liver. The other organs were apparently normal.

VAGINITIS FROM BESTIALITY.—The patient (*Weekly Med Rev.*) was "a smart, pretty, well educated" twenty-six-year-old country girl, who was found to be suffering from a profuse, thick, sticky, greenish yellow vaginal discharge of an extremely offensive odor, completely gluing the parts together. The discharge had been present for about a week, coming on suddenly. After washing the external genitals and opening the labia three rents were discovered, one through the fourchette and two through the left nymphæ. The vagina was found to be excessively congested and covered with bleeding points on the least irritation. Gonorrhœa was the presumptive diagnosis, but coitus was denied, albeit menstruation was stopped, and the patient was terribly perturbed about pregnancy. Under pressure, she confessed that one day she was playing with the genitals of a large dog. She became excited and thought she would have slight connection with him, but after the dog had made an entrance she was unable to free herself from him, as he clasped her so firmly with his fore legs. The penis soon became so swollen the dog could not free himself, and for more than an hour she made the most persistent efforts to do so, and finally making the ruptures before spoken of, and followed immediately by the discharges and inflammation. She was given the usual treatment for gonorrhœa, enjoining rest and soothing treatment until inflammation had subsided, since which time every kind of injection and treatment, applied both to the vagina and uterus, has failed to cure the discharge, pus cells being still abundant in the discharge; menstruation is normal. There was reason to suspect that the bestiality continued. The case is not unique, as Dr. I. C. Rosse (*Va. Med Monthly*) reports that a young white single woman was surprised copulating with a large mastiff, whose endeavors to release himself caused fatal vaginal hæmorrhage. The bony structures of the dog's penis, and the reversal attempted after completion of the canine sexual act, would be very likely to inflict wounds of the kind described in the first case.—*Medical Standard.*

THE NUTRITIVE VALUE OF ENEMAS OF RAW EGG-ALBUMEN.—In these days of peptonized and predigested foods it is well to remember that egg-albumen can be absorbed, under suitable conditions, from the large intestine without previous treatment with a proteolytic ferment. There is no question that the latter method of treatment is necessary for the absorption of coagulated proteids, and that it faciliates the absorption of fluid egg-albumen; but where it is desired to give an enema of the latter proteid (uncoagulated), peptonization is not a necessary preliminary step in its absorption from the large intestine, as both scientific experiment and practical experience testify. Huber has recently reported (*Archiv f. klin. Medic.* Vol. 47, p. 495) some interesting results bearing on these points which may perhaps be quoted with profit.

The persons experimented on were respectively, thirteen, fifty-one and seventy-five years of age, and during the experiments were fed upon a weighed diet of constant composition. Enemas were administered twice daily, and the absorption of the proteid matter contained therein was measured by daily determinations of the amounts of nitrogen excreted through the urine and fæces. The enemas were composed respectively of six eggs with six grams of sodium chloride, and six eggs which had undergone previous peptonization (with 200 cc. of 0.15 per cent Hcl containing considerable pepsin, warm at 40 c. for ten hours).

The amounts of albumen absorbed under these different conditions are shown in the following table:

	A.	B.	C.
Eggs emulsionized with water	24.75%	36.00%	29.80%
Eggs emulsionized with sodium chloride	58.25	70.09	69.50
Eggs peptonized	69.33	76.60	74.78

It is thus plainly manifest that simple emulsified egg-albumen can be directly absorbed through the mucous membrane of the large intestine. Further, that the addition of common salt fully doubles the rate of absorption, making it nearly equal to that of peptonized eggs. Evidently then, enemas of liquid egg-albumen emulsionizedwith a little sodium chloride must possess high nutritive value, if the above experiments are typical of the usual rate of absorption. —*Diet. & Hygen. Gazette.*

ITEMS.

A CHRISTIAN "scientist" has been indicted at Beatrice, Neb., by the grand jury for illegal practice and proposed to carry the case to the Supreme Court. We hope there is money enough, as reported, to carry this case forward. A Supreme Court decision is a thing yet to be on this question. It would not surprise us did it cause some undoing of all that has been done in the medical world. It is impossible to define the line *from a legal point* as to where faith and science should be parted in medicine.

MINNESOTA is possibly foremost of the Western States in success toward gaining just legislation which emanates from the medical profession. The Minnesota Medical Society are attempting now the passage of an act to regulate medical experts. Its purport is that the judge shall have the power to select the expert in all medical, mechanical and scientific questions, and that these experts shall be paid as witnesses for the State. Here is indeed a remedy for the evil which has crept into our courts of justice. Let some one in Nebraska frame the same law and push it forward. We may destroy an industry (sic), but laws are made for the people not the few.

PRESERVATION OF COCAINE SOLUTIONS.—According to Squibb, cocaine dissolved in a one-half per cent of boracic acid undergoes no decomposition on standing.

Wit and Humor.

The Creator Knows.—"Doctor," said the patient, "I believe there's something wrong with my stomach."

"Not a bit of it," replied the doctor promptly. "God made your stomach and He knows how to make them. There's something wrong with the stuff you put in it, may be, and something wrong in the way you stuff it in and stamp it down, but your stomach is all right." And immediately the patient discharged him.—*Amer. Anal.*

A Georgia Editor Wants His Money.—The following is from the pen of a Georgia editor who evidently had strong feelings on the subject: "The wind bloweth, the water floweth, the farmer soweth, and the subscriber oweth, and the Lord knoweth that we are in need of our dues. So come a-runnin' ere we go a-gunnin'; we're not funnin'; this thing of dunnin' gives us the blues."—*Ex.*

Had Authority for it.—Pastor—My dear, you should notdance. It is very wrong.

Young Belle—But I know one of the saints who approves of it.

Pastor—Impossible! Who?

Young Belle—St. Vitas.

Put A Strong Stick in it.—The drug-store proprietor had employed a new boy for $3 a week. "I'll have a little stick in mine," said the man at the soda-water counter. "A little what?" asked the boy. "A little stick," repeated the man with embarrassment. "In your soda-water?" "Yes, of course." The boy prepared the mixture. The man took a swallow, gasped, gurgled, and coughed, and, when he caught his breath, said, "What in thunder did you put in that soda-water?" "Well, sir," replied the boy, "I wouldn't have done it if you hadn't insisted; but as long as you wanted it I gave you the best brand of mucilage there is in the shop."—*Washington Star.*

Symptoms.—The Wife: There is a prescription that the doctor left for you to-day when he called and found you out.

The Husband: How did he know what to give me?

The Wife: He said that from my appearance and symptoms he knew you were suffering from chronic dyspepsia.

A Hopeless Case.—Doctor: Madam, I may put your husband on his feet again, but I fear that he will never quite recover the complete use of his nerves.

Wife: Oh, dear, what has John been doing to bring on such an attack?

Doctor: He has confessed all to me. He tells me that yesterday he was rash enough to drink a cocktail that was made in a drug store.—*The Club.*

It is one of the attributes of a good teacher that he knows how to say things in a way to make them remembered. During my second year at the Jefferson Medical College in Philadelphia, writes a physician in the New York *World*, I had a classmate whom it would not be uncharitable to call a dullard. One of the professors was in the habit of taking the boys unawares and quizzing them. He said to this fellow one day: "How much is a dose of——?" giving the technical name of croton oil. "A teaspoonful," was the ready reply. The professor made no comment, and the fellow soon realized that he had made a mistake. After a quarter of an hour he said: "Professor, I want to change my answer to that question."

"It's too late, Mr. ——," responded the professor, looking at his watch. "Your patient's been dead fourteen minutes."—*Memphis Medical Monthly.*

A Fatal Dose.—Fitz William: I found this here bottle o' Spring Bitters in a bar'l this mornin'.

Dusty Rhodes:—T'row it away, Fitzey. Sposen dey was to cure you of "that tired feeling!" You might want to work!

"Mamma, be late suppers bad?"

"Yes, my child, very bad."

"What makes 'em bad?"

"Why, it injures the health to eat just before going to bed."

"Oh, I thought maybe it injured the health to go to bed directly after supper."

Plaintiff's Attorney: "I've an expert who will swear he's insane."

Defendant's Attorney: "I've an expert who will swear he is of sound mind."

Plaintiff's Attorney: "Then let's pair off on experts and save that much money."

"Darling, how have you been to-day?"

"Oh, nervous, debilitated, sick, and unhappy."

"Heavens! You've been reading those medicine advertisements again, I'll bet a hat."—*Judge.*

Chipinone: "I understand Solomon Isaacs died suddenly. What was the cause?"

Uderdek: "Some one told him his life insurance would expire next day."—*Vogue.*

A well-known clergyman made a visit to a well-known banker and asked to see him in a private room. "I have come to you," he said, "with a message from dear Jesus. I am in financial trouble, and I have been looking round for somebody to help me out. I went to dear Jesus and asked him to send some one who would help me. He named you." "Are you sure," said he, "that he mentioned my name?" "Oh, I cannot be mistaken about it." "I recollect," said the banker, "that when the Lord sent Peter to Cornelius, He told Cornelius that Peter was coming. I think that if the Lord had sent you to me to get money, He would have intimated to me that He had done so. As He has not said anything to me on the matter, I must wait till I hear from Him.

Not an Expert.—"He writes about the drinking water of Chicago!" exclaimed old Sardonicus, glancing at the World's Fair correspondence in a New York paper. "If the 'Tom Vanson' that sends this stuff is the Tom Vanson I used to know, he's lived here off and on for the last six years and never tasted Chicago drinking water in his life!"

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ORIGINAL ARTICLES.

Inflammation About the Caput Coli.

(Continued.)

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As already remarked, the importance of inflammation about the caput coli was first recognized by American physicians and surgeons, and to their efforts we owe practically all of our accurate knowledge of this condition. So thoroughly and exhaustively has the subject been discussed in American medical literature that there would seem to be little more to add. We have, however, become so enthusiastic over the surgical aspects of appendicitis that clinical reports are of especial value as showing, on the one hand, cases in which operation is urgently necessary, and upon the other, those that recover without operative interference. My experience with what my friend, Dr. W. S. Christopher, is pleased to term "right iliac disease," while perhaps not so large as that of many others, has afforded me some very interesting cases for study. A recital of a series of some of the most interesting of my cases may be of interest.

CASE I.—Seen in consultation. A young lad, seventeen years of age, was seized with a chill and pain in the right iliac fossa three weeks before I saw him in consultation. He had previously been healthy, and gave no history of injury, or digestive or of bowel trouble. His physician informed me that at no time had there been a temperature higher than 101°. The pain had practically subsided at least a week before I saw him; the temperature had fallen and had not been higher than 100° for several days. On examination distinct induration was found in the right iliac region corresponding to the caput coli and involving an area nearly as large as the palm of the hand. Near the center of this area distinct fluctuations could be detected. Operation was suggested, but refused, and, in order to demonstrate to the physician and to the patient the necessity for operation, I aspirated the tumor with a hypodermatic syringe, withdrawing a fetid, sero-purulent fluid containing numerous fine flocculi of lymph. The tumor was not particularly tender on pressure. In spite of the ocular demonstration of the presence of pus, the patient still refused operation. Being curious to learn the result of conservatism in this case, I kept it under observation until complete recovery occurred, and I found that the conservatism of the patient and his friends had resulted in a complete cure. The young man told his physician a few days after I examined him that he had had a sudden and copious discharge of "matter" from the bowels, attended with a sense of something giving way in the abdomen.

CASE II.—A little girl, nine years of age, was brought to me by her aunt, a very intelligent woman. The child had been complaining of slight pain in the right side and had manifested an indisposition to play and run with the other children, as was her wont. Her bowels had been somewhat irregular, slight constipation and diarrhœa alternating with each other. She had apparently not been feeling very ill, but her aunt assured me that she had been looking very badly for several weeks. She also told me that the night before bringing the child to consult me she had looked her over herself, and had discovered a hard mass just above the groin upon the right side. On examination I found the characteristic induration about the caput coli and encroaching upon the region of Poupart's ligament. This was very slightly tender, immovable, did not pit on pressure, and presented no point of fluctuation. I immediately ordered the child to bed, with mild laxatives, and warned her friends of the possible necessity of an operation. The condition was so passive that at this time I felt that I was warranted in deferring operative interference. The child made an uninterrupted recovery, but had a recurrence about six months later. I suggested operation, but the case drifted from under my observation, and apparently again recovered without surgical interference. Whether or not more attacks have occurred—as is probably the case—I cannot say.

CASE III.—Seen in consultation. The patient, a lady thirty years of age, had been ill for five weeks. She had been suddenly seized with abdominal pain of a general character, which finally localized itself in the right iliac region. According to the statement of the attending physician, she had had quite an elevated temperature, running as high as 104° during the first week of her illness, after which the temperature had gradually decreased to 101°, and during the remainder of the time preceding my visit it had fluctuated between 101° and 102.5°. At the end of about a week after the onset of her illness the doctor informed me that he had detected a mass of induration in the right iliac fossa. This had gradually increased until the time I saw the patient, when it occupied the greater portion of the right iliac region, extending as high as the anterior superior spine of the ilium and nearly throughout the whole extent of Poupart's ligament. An obscure point of fluctuation was found just below the center of the indurated mass. Operation was advised, but declined. Tapping the tumor with a hypodermatic syringe, for the purpose of demonstrating the necessity for operation, revealed the presence of pus—not as fetid, however, as that which usually characterizes these cases. This case did very well without operation, an opening finally becoming established through the abdominal wall.

CASE IV. A young man, twenty-five years of age, who was under treatment for prostatic trouble, was attended by one of our prominent physicians for what was designated, an attack of malarial fever. Within three or four days the patient had been given permission to go out of doors; indeed, he had at no time been confined to bed. His first act, on being allowed to go out, was to visit me, and incidentally, while a sound was being passed into the urethra, he told me that he had been feeling badly for a few days, having been slightly constipated and having had malarial fever. He asked me if malarial fever was usually attended by severe pain in the right side, and being a little suspicious of cases of malarial fever with pain in the right iliac region, I gave him a thorough examination, and found that he had inflam-

mation about the caput coli from a probable appendicitis, there being a distinct, although not extensive, induration. I made a diagnosis of appendicitis, which was confirmed by my associate, Prof. Harold N. Moyer. The temperature at this time was only 101°, with a pulse of about 110. The pain and tenderness in the right iliac region were not severe. I advised the patient to go into the hospital immediately, with a view of having an operation performed within a day or two, providing marked improvement did not occur. He declined operation, however, and much to my consternation, stated that he was going back to his home in Pennsylvania immediately. I warned him of the risks of traveling in his serious condition, but my remonstrances were of no avail, and he started on his journey as he purposed. He arrived home safely and, somewhat to my surprise, recovered completely within a few weeks.

Case V.—A young man, thirty years of age, who had been under my care for stricture, urinary fistula, and nervous syphilis, had been feeling badly for a week. He had complained of malaise, anorexia, and pain in the right side. His trouble began immediately after having carried a heavy person up a flight of stairs. He felt the pain come on with a sense of faintness during the effort. I was suspicious of impending appendicitis, and, although there was no fever when I first saw him, I strenuously advised him to report frequently, so that I might keep close watch of his condition. I saw nothing further of him for a week, at the end of which time I met him accidentally while I was attending one of his friends. He at this time told me, quite incidentally, that he had been feeling worse and had had a chill the previous evening. On examination I found that he had a temperature of 103°. I immediately sent him home, put him to bed, and made a complete examination. I found great tenderness in the right iliac region, some gurgling, but nothing further to suggest trouble about the appendix.

The case was in many respects so much like one of typhoid fever that I was in doubt as to the diagnosis for two weeks. At the end of this time an induration appeared; for several days prior to its appearance, however, the patient had complained of pain and difficulty in straightening the right leg. He could only obtain comfort when the leg was flexed upon the thigh and the thigh upon the abdomen. As soon as the induration appeared the case was cleared up, and I proposed an operation, which was consented to. I found that the appendix, although enlarged and greatly elongated, contained no foreign body or perforation. It was, moreover, so closely adherent, that it did not seem wise to attempt its removal, and it was accordingly left. On exploring the abscess cavity thoroughly it was found to have burrowed upward in the direction of the kidney, the lower portion of which could be felt at the upper part of the abscess.

The contraction of the psoas muscle was easily explained by the course taken by the suppurative process. The pus had evidently formed posteriorly to the caput coli, and the process extended first upward in the direction of the kidney and then downward toward the iliac fossa. The wound was drained and dressed in the usual manner with rubber tubing and iodoform gauze. On the second day feces appeared upon the dressing, and continued to escape for about two weeks. The fever disappeared, and the day after the operation the temperature was normal. The further progress of the case was uninterrupted, and terminated in complete recovery. The patient was warned of the danger of a recurrence, but although the operation was performed several years ago, he has had no further trouble.

Case VI.—This case was seen through the courtesy of my friend, Dr. Bernays, of St. Louis. The patient was a man, about forty years of age, who had had several attacks of pain and inconvenience in walking, referred to the right iliac region. He had had syphilis, and on one occasion, when an induration had formed, had been treated with mercury and potassium iodide. On entering the hospital a mass of induration was found in the right iliac fossa, extending almost the entire length of Poupart's ligament. On evacuation by a long incision, parallel to Poupart's ligament, the iliac fossa was found to be occupied by an abscess with many loculi, and containing foul-smelling pus and masses of necrotic tissue. On passing the finger into the iliac fossa, it was found that the suppurating track extended high up behind the colon, in the direction of the kidney, and that it had burrowed in a manner similar to that observed in Case V. The same contraction of the psoas muscle had also been observed as in Case V.

Case VII.—Seen in consultation. A lady, forty-seven years of age, had suffered three months before I saw her with what was supposed to be typhoid fever. The history of the case, however, was a typical one of appendicitis. There was nothing in the family history to indicate tuberculosis. The onset of the illness had been quite characteristic of inflammation about the caput coli. When I first saw the patient an abscess was pointing just below the crest of the ilium, on the right side. This was found to communicate with the sinus passing over the crest of the ilium into the iliac fossa, and down in the direction of the caput coli. Secondary infection of the bronchial glands had occurred, with perforation and pyothorax. For the latter condition I performed Estlander's operation. The case improved for some little time, but finally an abscess developed above Poupart's ligament, upon the right side. This was opened, and was found to consist of a number of compartments occupying the iliac fossa. A communication was found to exist with the sinus of the previously formed abscess below the crest of the ilium. It was not deemed wise to open the peritoneal cavity at this time, nor has such operation at any time since appeared justifiable. I have held the opinion for some time past that the case has assumed a tuberculous character, and that the pelvic tissues have been quite extensively invaded. There is, of necessity, a serious gap in the history of this case, as I did not see the patient early in the case; but the history was so clear, as given by the attending physicians, as well as by the family and the patient herself, that personally I have not the slightest doubt of the appendicular origin of the trouble.

Case VIII.—The patient, a woman of thirty-two, had suffered for some time from utero-ovarian trouble, unquestionably of gonococcal origin. She had also had, from time to time, attacks of indigestion, as she termed them, accompanied by considerable abdominal pain. I had seen her in one attack of this character, which was unquestionably an attack of appendicitis of a mild type. I had also treated her for uterine disturbance. The attack under consideration

began with severe pelvic pain, radiating down the thighs and into the lumbar region. This was attended by fever, the temperature being about 101.5°. The usual line of treatment for pelvic inflammations was instituted. For about two weeks the case pursued the characteristic course of a severe pelvic peritontis due to infection. At the end of this time intense pain in the right iliac region came on, with great tenderness over the entire right side of the abdomen, and an increase in the fever, the temperature rising to 103.5°. Under hot anodyne poultices the local condition improved somewhat, but after two or three days of comparative comfort I was hastily sent for, and was informed that the patient had been suddenly seized with severe abdominal pain, which was attended with faintness. For some days there had been a distinct tumor occupying the entire region of the colon, and the immediate inference to be drawn from the condition of the case was that either a perityphlitic abscess or a pus tube had ruptured. That pus tubes and severe perityphlitic inflammation coexisted in the case appeared to be certain. I proposed an operation, but the family requested that I obtain counsel, and I, therefore, called in Professor William E. Quine, who counselled against operation. Much to my gratification and surprise, that part of her condition referable to the colon improved very rapidly within a week or so, the patient at the same time passing a large amount of feces. The pelvic inflammation did not improve as rapidly as could be wished, and on my again suggesting an operation the case drifted out of my hand. I understand that she fell into the hands of a very competent physician of this city, who obtained an apparently successful result by simple local measures.

Case IX.—A young lady, eighteen years of age, came under my care, suffering with severe pain in the right iliac fossa. She had previously been operated on for appendicitis, and, according to the statement of the attending physician, the appendix had been removed. As the physician in question is a very competent man, there can be no doubt upon this point. The patient appeared to be extremely neurotic and hysterical. The spine presented numerous points of tenderness, and, in short, was in a condition characteristic of so-called irritable spine. No tumor could be detected in the right iliac region, and upon this diagnosis I based my treatment. The case finally passed out of my hands into those of my friend, Dr. Senn, and the patient was eventually cured by the application of the actual cautery to the spine.

I would not introduce this case into this series of observations, excepting to illustrate the fact that even though the appendix may be the starting point of quite serious disturbance, pain may persist after the removal of the offending structure. One can readily imagine also that cases of a purely neurotic character may arise in which a mistake in diagnosis can easily be made.

Case X.—A young man, eighteen years of age, was suddenly seized with pain in the right iliac region, fever and vomiting. He was treated, for three days before I saw him, by the application of hot fomentations to the abdomen and the internal administration of quinine and opium. When I saw him the pulse was 140 to the minute; the temperature subnormal; the extremities cold; and the abdomen swollen, and tense as a drum. Surgical interference was out of the question, and although I had been sent for with a view to operative interference, I declined to operate, stating as my opinion that the boy could live but a few hours, and that operation would simply hasten the end. Death occurred twelve hours after my visit.

Case XI.—A gentleman, thirty-five years of age, was referred to me, with a distant history of three, and perhaps four, attacks of appendicitis. At the time I saw him he was going about and attending to his usual affairs, although in the midst of what he designated a moderate attack of his old trouble. He stated, however, that the attack prior to the one for which he consulted me seemed to be worse than those which preceded it. There was a slight induration in the region of the appendex, very slight fever, and no marked disturbance of the bowels. He stated that he had suffered for the greater part of the time from a moderate degree of constipation alternating with a slight diarrhœa. The nature of the trouble was explained to the patient, and operation proposed and consented to. I found, on opening the abdomen, that the appendix was greatly enlarged, thickened, and bound down by adhesions. There was but a small amount of pus about the appendix —the quantity, I think, not exceeding two drachms. There was no perforation of the appendix and no foreign body in its cavity. Recovery was uninterrupted, and the patient has since remained free from trouble.

This case, perhaps, does not present any features of extraordinary interest, but it happens to be the only case of recurrent appendicitis upon which I have operated, although I have operated in primary attacks quite frequently.

Remarks.—Case I. is an excellent illustration of the manner in which some cases of appendiceal abscess will discharge spontaneously into the bowel after a distinct purulent accumulation has formed. It is unfortunate in one respect that such cases occur, for in the hands of some so-called conservatives they are used as a powerful argument in favor of conservatism in all cases.

Case II. is an illustration of the insidious character of some cases of appendicitis, and shows that an induration may form about the appendix with very little local or no constitutional disturbance. It also shows that in young children distinct and typical induration may occasionally be met. It may be remarked in this connection, that in young children in whom the peritoneum is relatively very sensitive, inflammation may begin in the appendix and result very rapidly in a fulminant peritonitis, which destroys the life of the little patient very quickly. Under such circumstances no induration forms, and the inflammation when diagnosticated by the physician is already of a general character. Such cases, I am confident, form a large proportion of the cases of so-called idiopathic peritonitis in children.

Case III. is of a somewhat similar character, but I will embrace the opportunity to suggest that until we have some means of determining and controlling the direction of least resistance to the escape of pus in such cases they should receive very little consideration as arguments against operative interference. This much may be said of such cases, that an operation upon them is practically extra-peritoneal, and is but little more dangerous than the opening of an ordinary abscess in any other situation. Another point with regard to such cases when operated upon is,

that they have been the source of the greatest glory to some operators. In formulating statistics of the results of operative interference in inflammations about the caput coli, the trifling importance of some operations made upon such cases should be taken into consideration.

CASE IV. is an excellent illustration of (1) the ease with which inflammation about the caput coli may be overlooked, and (2) of the fact that some patients bear a charmed life and will escape serious results in spite of all their efforts to destroy themselves. Most surgeons would have considered that an immediate operation was justifiable in this case, yet the patient took a long railroad journey, and not only escaped serious results, but completely recovered without an operation.

CASES V. and VI. are interesting from several standpoints. In the first place, the tardiness with which the pus came to the surface is quite noteworthy. This point, associated with the marked and painful psoas-contraction, is worthy of consideration in doubtful cases as indicating a retrocecal location of the suppuration. Obviously when pus forms in this location it is slower in coming to the surface, and the induration may not be detected for some time, and a mistake in diagnosis is likely to occur. A valuable point for consideration is the similarity of cases of this kind to the cases of acute psoas-abscess reported by my friend Dr. J. McFadden Gaston, in the *Transactions of the Southern Surgical and Gynæcological Association* for 1890. There is a question in my mind whether some of Dr. Gaston's cases may not have been similar in character to Cases V. and VI. The question of the possible traumatic origin of Case V. is well worth consideration. The fact that both cases had been affected by syphilis is interesting, although it probably has no etiologic bearing upon either case.

CASE VIII. is one of the most interesting of the series. Here was a woman suffering with two conditions, either one of which taken alone, according to our modern views, urgently demanded operation, yet in which complete recovery occurred without operation.

CASE IX. shows very clearly that conditions of a painful character in neurotic patients may apparently be perpetuated after the removal of the original cause. Physiologic habit is perhaps a weak explanation, but reflex disturbance of the nervous centers by peripheral irritation is seen sufficiently often to afford a logical explanation of such cases. Only too often a diagnosis of reflex irritation is questioned, because after the removal of the supposed *fons et origo mali* the symptoms still persist. It must be remembered, however, that prolonged pain means prolonged irritation in the presence of a real pathologic condition. This prolonged irritation may not only result in more or less impression upon the nerve centers, but it may result as well in a disturbance of nutrition, even amounting to a neuritis of the nervous filaments immediately involved.

CASE X. is a beautiful illustration of the fact that there are some cases in which conservatism is little short of murder. The physician who stands over such a case, with a poultice in one hand and a hypodermatic syringe in the other, while, for obvious reasons, he may never be subjected to a suit for malpractice, certainly cannot justify his position in his own conscience if he be not wofully ignorant of the present status of abdominal surgery and medicine. Had I operated upon this case there would have been another failure, for which the conservative man who had preceded me in the case would have given due credit to the abdominal surgeon. The trouble with most of our statistics is that they include not only the cases of men who lance abdominal abscesses, but the cases of men who operate upon patients who are in a moribund condition—who perform, in other words, a premature post-mortem. Cases of this kind form a large proportion of those cases of idiopathic peritonitis that we hear so much about and so seldom meet. My experience with this class of cases has been that the man who proposes to operate should do it then and there, and not postpone it to see how the patient will feel in the morning.

CASE XI. shows that perityphlitic inflammation and suppuration may occur in the absence of gangrene, perforation, or foreign body in the appendix.

While visiting the Detroit Medical Library Association a short time since I saw a specimen of a similar character presented by Dr. T. A. McGraw.*

In conclusion, I will state my belief that the least that can be said of the foregoing series of cases which I have presented is that they illustrate the fact that there is a large number of cases in which we have no accurate basis for determining the advisability of operation on the one hand or of conservatism on the other hand. I might say, in passing, that we are not likely to obtain any very definite ideas upon this subject until a better classification of the cases that have been subjected to operation and those that have recovered under conservative measures has been made. There is absolutely no resemblance, for example, between such cases as are illustrated by Cases II. and X., yet they are classified from a diagnostic and operative standpoint in the same category. Another point which I desire to insist upon is that there is too much operating upon patients who are in a moribund condition. Every failure under such circumstances goes to detract from the value and safety of operative interference in cases of appendicitis, and no part of the blame is assumed by the physician—who, perhaps, should assume all responsibility, inasmuch as he sent for the surgeon only when he found that the patient was *in extremis*.

834 OPERA HOUSE BLOCK.

Individual Experience in the Treatment of Vesical Calculus.†

BY JOHN ASHHURST, JR., M. D.

I FIND in looking over my records that I have removed calculi from the human body in fifty-one cases. One case was that of a female child, on whom I performed lithectasy, or rapid dilatation of the urethra, but the remaining fifty were in male subjects. In thirty-five of these fifty cases the patients were operated on by lateral lithotomy, which is the cutting operation that I prefer. I recognize that there are cases in which the median operation is to be preferred, and that there are other cases in which the suprapubic operation is the best, but where the surgeon has the

*Such cases may have a direct bearing upon "appendical colic." J. F. Binnie, *Annals of Surgery*, June, 1893.

†Read before the Philadelphia Academy of Surgery, May 1, 1893

choice of operation, I think that he should select lateral lithotomy. Of the thirty-five cases operated on by the lateral method, twenty were in children under the age of puberty, and in every case the patient recovered. In males beyond the age of puberty, including a fair proportion of quite old persons, I have had fifteen cases with three deaths, but only one of these three was really the result of the operation. That occurred in a case operated on in a neighboring town this winter. Secondary hemorrhage occurred on the ninth or tenth day, and the attempts made by the attending physician to control it were not successful.

I have six cases of the median operation, with one death, to report. In one case the operation was done for the removal of a foreign body, the end of a catheter. In this case I succeeded not only in removing the foreign body, on which there was a small calcareous deposit, but also in relieving the chronic retention of urine, from which the patient had long suffered, by tearing off the median lobe of the prostate with the forceps. This was fully ten years ago; the patient is still living, and I believe has not had occasion to use a catheter since. The case which proved fatal was in a patient in the last stages of cystitis and chronic renal disease, and in which the presence of the stone was simply a complication. An interesting feature in this case was that, in addition to the presence of a stone, there was a large quantity of that semi-organized material which has been described by Vandyke Carter as the animal basis of calculi.

I have one case of the supra-pubic operation in which the stone was a small one, this particular operation being chosen because the case was really one of villous tumor of the bladder, and the presence of the stone was simply a complication. The patient was in a critical condition from hemorrhage at the time of the operation, but made a good recovery.

I have no case of the old-fashioned lithotrity. The operation had already come to be rarely practised before I had occasion to resort to the crushing method. The early portion of my practice was largely with children, and Bigelow's modification had already become the operation of preference when I first felt I had a case adapted to its performance. I have performed this operation eight times, with six satisfactory recoveries and two deaths. Both deaths were from uræmia, dependent upon chronic diseases of the kidney.

I have brought here a number of the calculi which I have removed. The largest weighs three ounces and some drachms. It was removed by the ordinary lateral operation. It was not necessary to enlarge the wound by dividing the right side of the prostate, nor was it necessary to crush the stone. By making a large external wound, by grasping the stone with sufficiently powerful forceps, and by patience in manipulation, this stone was removed without difficulty, and the patient made an excellent convalescence.

The largest number of stones which I have removed from one patient is fifty-four. These were removed by lateral lithotomy. The patient made a good recovery, but returned in a year or so with recurrence of the symptoms from a descent of more stones from the kidney. On that occasion I determined to perform the operation of litholapaxy. The patient did pretty well for a few days, but then the urine became turbid, containing a large quantity of ropy mucus and pus, uræmia developed, and the patient died in convulsions. This was a forcible illustration of the risk attending litholapaxy in the cases of cystitis, and since the occurrence of that case I make it a rule, where the patient presents cystitis in an advanced degree, to recommend the cutting rather than the crushing operation.

With regard to the results that I have reached from my own experience, I would say, in the first place, that I have never seen any reason to wish for a better operation than lateral lithotomy in children. Litholapaxy has been resorted to successfully a number of times, and with the improved instruments which we now have the operation is a feasible one, while it could hardly be considered such a few years ago. Until within a short time it has not been possible to get instruments of sufficient strength and delicacy for use in the urethræ and bladders of children. Even now, the operation of litholapaxy in children seems to me to be a more severe one than lithotomy. The results of cutting for stone in children are so satisfactory that I think we want nothing better. The great advantage of litholapaxy it seems to me is the short time required for aftertreatment. If all goes well, litholapaxy will allow the patient to go about his business in five or six days. This is a great advantage in adults who are ingaged in active business; but in young children it is a matter of no importance. At the same time I am willing to admit that the operation has been improved to such an extent that it is one which my be legitimately resorted to in children if the surgeon thinks that it is preferable.

The median operation seems to me to have a very limited field. Cases of foreign body in the bladder, and cases of very small stone, are those to which this operation is adapted. In some of my cases the operation was not begun with the knowledge that a stone was present, but for retention of urine where it was not possible to pass an instrument by the urethra. The argument which has been advanced in favor of this operation, that it is attended with less risk of hemorrhage, does not seem to be entirely well founded. There is very little more risk in the lateral operation. The transverse perineal artery is divided, but with a little care it is not likely that the internal pudic or the artery of the bulb will be injured. In the old days of operation without an anæsthetic, it was quite possible that one of these arteries might be wounded in the struggles of the patient. The artery of the bulb can be avoided by striking the staff as far back as possible. The hemorrhage from which I have had trouble has been from the prostatic plexus of veins, and this is quite as likely to occur in the median as in the lateral operation, and, indeed I have seen very profuse hemorrhage from this source after median section.

The supra-pubic operation, although just at present the fashionable method, I should reserve for very large stones, or for cases in which there was some complication, such as tumor, in addition to the stone. Cases of vesical tumor are more satisfactorily dealt with through the supra-pubic incision, but where the case is an uncomplicated one of stone, I have not seen any reason to prefer this to the lateral method.

In the female, the operation of lithectasy or rapid dilatation is the one to be chosen, and in almost all cases will be sufficient. Mr. Bryant has shown that stones of considerable size can be removed by this method. In children, stones up to half an inch in

diameter, and in adults stones up to one inch in diameter, can be thus removed. If the stone is larger, it can be broken into several fragments before removal. I believe that the results of this method will be more satisfactory than if an attempt is made to remove the calculus by litholapaxy or by any form of lithotomy. The vesico-vaginal section may leave a permanent fistula. The high operation may, of course, be required for very large stones.

As regards the operation of lateral lithotomy, the points which are to be observed are, in the first place, to make a large external wound. I have seen very serious trouble result from too small an external incision. There is no objection to a large wound through the skin and superficial fascia; if hemorrhage occurs, it is easier to deal with it through a large wound, and drainage is more satisfactorily effected. In the second place, I think that it is of great importance to strike the staff as far back as possible. Instead of striking it where it is most superficial, I endeavor to get as far back toward the horizontal portion of the staff as possible. In that way you avoid wounding the artery of the bulb, and obtain plenty of room where it is needed. My preference is to have the staff firmly hooked up under the pubis, instead of having it made to project in the perineum. I believe that in this way it is more firmly held, and that the surgeon can fix the position of the anatomical points better, and therefore cut with more precision. Having struck the staff, I think, following the advice of Sir William Fergusson, that the deep incision should be made small. I believe that there is a decided advantage in this plan. I do not say that the surgeon should not make the wound in some degree proportionate to the size of the calculus, and in cases where there is a large stone, I am in the habit, as I withdraw the knife, of bringing it slightly away from the staff so as to enlarge the deep wound. In children the knife should be withdrawn in close contact with the staff; but in the adult I drop the knife a little, so as to enlarge the wound in the prostate. The finger is then introduced, and the prostratic enlargement completed by dilatation. I do not at all agree with the view of Mr. Teevan, that it is safer to cut the prostate than to stretch it. In the introduction of the finger, I lay stress on its introduction above the curve of the staff. In children this is very important, for if it is not done, the finger may not enter the bladder, but may pass into the recto-vesical space. The surgeon cannot miss the bladder if he passes the finger above the staff, as it is well held up under the pubis.

In my earlier operations I had a great fancy for the scoop in removing calculi, using it as the obstetrician uses the vectis, getting the scoop behind the stone and the finger in front of it, and bringing all out together. Of late years I have used the forceps more and the scoop less, although at times it answers a useful purpose. In the withdrawal of the stone, a mistake that I have often seen made is in not carrying the forceps far enough backward toward the coccyx. The portion of the wound where there is plenty of room is far back: I have seen surgeons try unsuccessfully to remove the stone through the interior portion of the wound, when it could have been readily removed if the forceps had been dropped toward the back.

In the high operation, it is a great advantage to have the bladder and the rectum distended, though, perhaps, not absolutely necessary. There is an advantage, too, in lateral lithotomy, in having a moderate quantity of fluid, say about four ounces, in the bladder before the operation, as the gush of water, when the bladder is opened, will bring the stone down on the end of the finger. If, however, the bladder is intolerant, I no not care to have it much distended.

With regard to the operation of litholapaxy, the points which I consider to be of importance, are, in the first place, to crush the stone as thoroughly as can be done, and then, when using the evacuator, to make the stream enter with great gentleness. I believe that cystitis may be aggravated or even caused by using too much force. As regards the rapidity of the operation of litholapaxy. I have no doubt that an operator will do it with greater rapidity as he does it oftener, but for own part, I have found it a slow operation. I think that no surgeon should undertake it who is not prepared to give as many hours to it as may be necessary. I can recall three cases in the practice of other surgeons in which the patients died as the direct result of having a stone left half crushed in the bladder. Violent cystitis came on and the patients succumbed. Where the operation is undertaken, it should be completed. If the surgeon is not prepared to remove the entire stone at one sitting, he should not undertake the operation at all. This is the operation for small stones in patients with healthy bladders. Cystitis is the most dangerous condition in which to resort to litholapaxy. In the case of an adult presenting himself with stone, my first thought is of litholapaxy. I then consider the various cir cumstances in the case. Litholapaxy has so many advantages in cases to which it is adapted, that I think it should be the surgeon's first choice.

With regard to the objection that lateral lithotomy may render the patient sterile, I do not see why that should be, provided that the operation is confined to one side of the perineum, and that no undue amount of inflammation follows. If there were a great deal of inflammation, it is quite possible that there might be such obstruction of the vas deferens as to prevent the patient from generating with the testis of that side, but there is no more reason why the patient should be rendered sterile by the operation of lateral lithotomy than by the removal of one testicle. In the immense number of operations performed in former years, we never heard of this objection, and I believe that it is rather theoretical than practical.

I have had one case of stone weighing less than two grains, which I diagnosed by the sound, and removed by lateral lithotomy. The patient was a lad who had the symptoms of stone in the bladder, and in addition, frequent attacks of sudden and complete retention of urine, due to the calculus entering and plugging the internal meatus. The straining was so excessive that, in the effort to pass water the night before the operation, the patient ruptured sub-conjunctival vessels in both eyes.

I wish to refer to a few cases of cystotomy for other causes than calculus. I do not include cases where I have operated by Sir Henry Thompson's method of puncturing a contracted bladder above the pubis. I find that I have opened the bladder by cystotomy in eight cases, six of these being cases of cystitis. Of these six, four recovered, and two died, as the result of the diseased state of the urinary organs. In two instances I have opened the bladder for intense pain in the act of micturition, due to a fissure at the neck

of the organ. Both patients recovered. In one case the fissure followed cystitis, the result of gonorrhœa, and in the other case, the symptoms came on after the use of very large sounds.

I have had one case of cystotomy in a child for tuberculous disease of the bladder. This case was of a good deal of interest. The patient had, at one time, been under the care of the late Prof. S. D. Gross, who had sounded the child, and said that he felt a stone. It is to be observed, however, that he never appointed a time to operate, so that it is possible that he may have had some doubts as to the diagnosis. A curious feature of the case was that the father, who was a man of considerable intelligence, declared that he had himself distinctly heard the click of the stone against the instrument. I sounded the child, but was not entirely satisfied that a calculus was present, although, from the history, I thought it probable. The child had all the usual symptoms of stone, except sudden arrest of the urine. I asked Dr. Forbes to see the case with me, and we thought it right to open the bladder. No stone was found but there were discharged twenty or thirty little bodies which I presume were what the older surgeons would have spoken of as fibrinous calculi. They looked like little pieces of catgut. Whether these were masses of tuberculous material, or of inspissated mucus and lymph, I do not know. The patient was relieved of his symptoms, but died two months afterward of tuberculous disease of the mesenteric glands.

SALT AS A SWEETENER OF SUGAR.—Sugar and salt are sometimes held to be incompatible or antagonistic in their action on the organs of taste, but it is a common social experience that the addition of the slightest dash of salt adds flavor to sweet coffee, and sugar cured hams have their own reputation, while meat and vegetables cooked "sour and sweet" are a favorite delicacy in Germany. Prof. Zuntz, at the Physiological Society of Berlin, definitely explained the making of sugar sweeter by the addition of salt. From his experiments, he finds that if to a solution of sugar there be added a slight amount of salt and water, so weak that it excites no saline taste, the result is extra sweetening of the sugared water. The weakest of quinine solution is said also to produce similar results. The explanation given of the above seeming incongruity is that the ever so feeble saltness bitterness imparts an increased sensibility to the sensation of taste by the simultaneous stimuli, and hence an appreciation of additional sweetness.—*British Medical Journal.*

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

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G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Biographical Sketch of Dr. S. V. Clevenger, Superintendent Illinois Eastern Hospital for the Insane.

Dr. Clevenger's father was an eminent Ohio sculptor who died at sea while returning from Italy, where Dr. Clevenger was born in 1843.

Dr. S. V. Clevenger.

During the civil war the doctor was in the United States Engineer Corps which performed sapper and miner service in the Army of the Cumberland.

At the age of 20 years the doctor received his commission as first lieutenant and was placed in command of Sherman Barracks, in Nashville, in which were, at times, 5,000 recruits to be assigned to their regiments, clothed, instructed and drilled. During the Siege of Nashville, in which battle the doctor participated, he met the lady who became his wife. Their children are Albert, an electrical engineer, Shobal, a Wyoming ranch owner, and Martha, who is an accomplished pianist.

The doctor continued civil engineering after the war and surveyed extensively in Montana, Dakota, Nebraska and Iowa. Just before resigning as United States Deputy Surveyor and Chief Engineer of the Dakota Southern Railroad, he built 300 miles of telegraph line in Dakota, in which he owned a third interest, and published a work on surveying, which is after twenty years still a standard text-book in every university and used by all United States surveyors inthe field.

Becoming disgusted with the contact of politicians who controlled government surveying during Grant's presidency, he concluded to study medicine and at Ft. Sully, Dakota, while meteorologist of the United States Signal Service, was instructed by the post-surgeon and his assistants, finally graduating some six years later at the Chicago Medical College in 1879, and in 1883 to 1885 was pathologist of the Cook County Insane Asylum, where he was offered

the superintendency, but declined it, as he could not reconcile his views as to how an asylum should be conducted with the horrible mismanagement of the county commissioners. For years the doctor by tongue and pen has protested everywhere in the public press, in medical journals, scientific and medical societies, against political control of the insane, and some of his efforts nearly cost him his life, for he was shot at, and endeavors were made to entrap and murder him by the politicians whom he assailed.

After leaving the asylum he became alienist and neurologist to the Michael Reese and Alexian Brothers Hospitals, positions which he has filled the past ten years. His practice was largely medico-legal in insanity cases.

In 1885 he published "Comparative Physiology and Psychology," and in 1889 "Spinal Concussion," a medico-legal treatise.

He was appointed superintendent of the Illinois Eastern Hospital for the Insane at Kankakee by Gov. Altgeldt on his past reputation and without reference to politics. The doctor refused to accept the position while Dr. Dewey was a candidate for reëlection and it was only after the latter had resigned that Dr. Clevenger signified his willingness to take control.

Every physician and employe that Dr. Clevenger found in the hospital was retained without an exception and the civil service policy of President Cleveland and Governor Altgeldt is enforced there. The merit system prevails and promotions are made for good behavior, while dismissals are only for unfaithful service. Two such only have occurred during Dr. Clevenger's incumbency, one attendant discharged for beating a patient, and a superfluous officer, called a food inspector, who was more of a detriment than help to the proper care of the insane.

The doctor has appointed a staff of visiting physicians, such as dermatologists, gynæcologists, laryngologists, oculists and otologists, dentists, surgeons, etc., besides having a resident lady gynæcologist and lady alienist assistant. The resident staff consists of ten physicians, the employes number 300 and the patients 2,000. The buildings cover 40 acres of ground, the farm containing 800 acres.

The pathologist of the hospital is Dr. Adolf Meyer, of Zurich, who studied in Paris, London and Vienna, and is professor of histology in the Chicago University.

The hospital under Dr. Clevenger's administration will be heard from still further as one of the best managed in the world.

The doctor inaugurated staff meetings where the physicians discuss all business relating to the proper care of the patients and medical topics to the same end.

[Since this was written Dr. Clevenger's health has failed under the pressure of asylum work and he has resigned to resume private practice.—Ed.]

New Superintendent. Dr. S. V. Clevenger, having resigned the superintendency of the Eastern Illinois Asylum for the Insane, at Kankakee, Dr. Clarke Gapen, of Chicago, has been elected to fill the vacancy. The new incumbent was formerly connected with the State Hospital for the Insane and the State University, of Madison, Wis. At present he holds a professorship in the College of Physicians and Surgeons, of this city.

Abstracts.

Medicine.

Preventive treatment of cerebral hemorrhage. —Dr. Joseph Collins discussed this interesting subject before the New York Post-Graduate Clinical Society, in January (*reported in the Post-Graduate.*) He says attention has been directed more to the treatment than to the prevention of hemorrhage.

The chief underlying cause hæmorrhage is a condition known as arterio-renal disease, a disease first manifested in the blood, afterward in the kidneys and heart, and is, perhaps, dependent on a lesion of sympathetic ganglia. The premonitory spmptoms of cerebral hæmorrhage are vertigo, a hard, firm, full and incompressible pulse, a persistent habit of waking at an early hour in the morning, being unable to sleep again, drowsiness during the day due to inelasticity of blood-vessels in the brain, headache, particularly toward evening, and a tendency to forget names. Such symptoms should be fortified by examination of the urine and use of sphygmograph, ophthalmoscope and stethoscope. The urine will be of low specific gravity and the quantity of urea diminished. It is important to collect the urine for twenty-four hours.

When the urea is found to be quantitatively or relatively diminished, it is indicative that the protoplasmic changes in the blood are not sufficiently rapid to thoroughly complete oxidation or are not complete. Retention of these by products follows, and to these can be attributed many of the preceding symptoms of cerebral hæmorrhage. The ophthalmoscope will show retinal changes indicative of arterio-renal disease; the stethoscope will show the heart changes and the sphygmograph will show changes in pulse beat.

Preventive Treatment: Remove the cause, such as syphilis, gout, rheumatism, etc., and correct the by-products of nitrogenous metabolism. To this end give bichloride of mercury, first, to improve the nutrition of the blood and vessels; it stimulates blood-elaborating organs and, perhaps, blood-producing organs. To relieve blood pressure without diminishing heart action, nitroglycerine is recommended, in doses of 1-200 grain. It restores the pulse rate and relieves the cerebral symptoms. Bromide of sodium is also efficacious under like circumstances. Veratrum viride diminishes heart action, and is preferred to aconite when such treatment is indicated. The digestive tract must be cared for; this is imperative. Care should be used in exercise, especially avoiding jumping out of bed and hurriedly relieving the bladder of the night's accumulated urine. When an attack occurs give nitroglycerine in preference to ergot, which increases blood pressure, which is to be avoided if possible.—*Med. Fortnight.*

Treatment of Tonsillitis.—Although acute tonsillitis is quite amenable to treatment we have hardly succeeded in producing complete relief in the short time named by Dr. Newcomb in his report of the treatment of 169 cases.

He divides these cases into three groups. Of those of the first group the treatment was begun on the first or second day. Of the second group the treatment was begun on the third day. Of the third group the treatment was begun after the third day.

Three distinct agents were used in the treatment

of these cases, viz., salol, guaiac and salicylate of sodium. Eighty-one cases were treated with salol in five grain doses.

In these cases the patients expressed relief from the symptoms in an average of fourteen and a half hours.

Forty-four cases were treated with guaiac. These were relieved in seventeen and a third hours. Forty-four cases were treated with salicylate of sodium, and were relieved on an average in eighteen and a half hours.

From this observation salol would seem to be a remarkably efficacious remedy in the treatment of this common disorder.—*Med. Times.*

Acute Ulcerative Endocarditis Due to the Bacillus of Diphtheria.—Howard (*Bulletin Johns Hopkins Hospital*) records a case of acute endocarditis due to the diphtheria bacillus. The affection was in a man aged 44. It began in a chill, high fever, pain in the head, abdomen and limbs. The disease ran a course lasting seventeen days. The endocardium was found to be rough, ulcerated and hemorrhagic. The spleen, liver and kidneys were diseased. Cover-glass preparations, made from a thrombus mass on the mitral valve and from the spleen and kidneys, all showed the presence of a bacillus with all of the morphological characters of the bacillus of diphtheria. This bacillus was the only organism found. Tubes of glycerine agar were inoculated from the mitral valve, the lungs, the liver, spleen and kidneys, all of which developed pure cultures of this bacillus. This germ has been studied by Prof. Welch and Dr. Abbott, as well as by the author, and the only point in which it was found to differ from the dipththeria baccillus was its failure to kill experimental animals. The microscopic examination of the tissue showed the bacilli to penetrate to the depth of only two to three layers of cell in the endocardium. The histological study of the organ demonstrated the fact that the bacillus concerned in the lesions present is to a certain extent a pus-producing organism. There was a decided hyaline degeneration noted in the muscle tissue of the valves of the heart. As the author states, "the striking points in this case are a malignant endocarditis with general infection caused by a bacillus that is morphologically and by culture methods indistinguishable from the bacillus of dipththeria." Here we have not only a wide distribution of the bacilli in the body, but the primary lesion situated in a very unusual place (endocardium). Although this bacillus failed to kill guinea pigs, others have found the Klebs-Loeffler bacillus unable to destroy these animals. According to Prof. Welch, this is the first time that the bacillus of diphtheria has ever been found to be the cause of ulcerative endocarditis.—*Med. and Surg. Reporter.*

Morphine and Gastric Secretion.—Hitzig has noted that morphine administered hypodermically to a dog is shortly afterward excreted by the stomach, and that, following upon this, there is a marked reduction in the amount of gastric juice secreted, and more especially of its acid constituent. The cessation of the action of the drug is followed by the secretion of excess of hydrochloric acid. With regard to the effect upon human gastric juice, the case is described of a patient who consumed daily two grammes each of morphine and cocaine, the latter having been resorted to in an endeavor to remove the craving for the morphine. He was treated by gradual reduction of the doses of the alkaloids, but it was not until the morphine was entirely discontinued that the presence of free hydrochloric acid was indicated.—*Neur. Centr. Med. and Surg. Reporter.*

Cancer of the Rectum. — Dujardin-Beaumetz claims to obtain by the following medication better results in patients affected by cancer of the rectum than is obtained by surgical intervention. Each day an intestinal irrigation is practiced with a liter of water containing from 0.10 to 0.20 (gr. jss to iij) of naphthol. The patient should be on the back. At each meal is eaten one of the following cachets: Salol, benzo-naphthol and sodium bicarbonate, each 10 grams (ʒ ijss). Divide into thirty cachets. Vegetable alimentation is recommended, with little meat, especially gelatinous meats that have undergone a prolonged boiling. Laxative are given when required.

Patients submitted to this treatment have gained in flesh, and have been able to continue to live as the rest of the world, which is impossible when they have undergone an operative procedure.—(*L'Annee Med., American Therapeutist.*

Surgeon's Plaster in Chilblains.—Dr. Goemer (*Medicinische Neuigkeiten*), finds surgeon's plaster to be a simple and reliable remedy in chilblains. It is especially serviceable when the feet are attacked; it is easily applied to the big toe and heel. A salicylated plaster is of greater value, as it helps any decorticated spots to heal. The plaster is applied and allowed to remain on for three days, when the trouble will be found cured. After this it will possibly have to be renewed on account of its soiling easily. It may be used on the hands of cooks, and those who work in water.—*Lancet Clinic.*

A Bacillus of Ozæna.—Abel describes a bacillus which he believes to be pathogenic of ozæna. It is found with many other organisms in the muco-pus beneath the scabs, and is not found in other varieties of nasal secretion. It grows upon the ordinary culture media, with the production of a peculiar odor, like that of fermenting malt. It does not produce spores, but lives long in a dry state. The author was unable to produce ozæna in animals. He believes that this specific organism does not directly cause the well-known odor, but that this is due to various organisms always found associated with it, capable of decomposing albuminous substances, and that the organism itself merely excites a peculiar secretion in the nasal mucous membrane, which differs from the ordinary secretion of chronic inflammation in being capable of putrefaction.—*Boston Medical and Surgical Journal.—Med. Age.*

Separation of an Intussusception without Symptoms.—At the Medico Chirurgical Society of Edinburgh, Dr. Robert Abernethy showed some microscopic sections from a piece of tissue which had been passed per rectum by a patient in the Royal Infirmary. The patient was under treatment for pernicious anæmia, and was in an extremely low condition. Ten days after admission, without any previous symptoms pointing to intussuseption, but following a marked rise of temperature, he passed a mass of pulpy gelatinous tissue five inches long and two and

a half inches broad, which at one end formed a tube which was invaginated. Microscopic examination showed that it consisted of the whole thickness of the intestine. The patient was now doing extremely well in every respect. The President said the case was one of extraordinary character, and ought to be well considered. He did not think there was anything of the kind in surgical literature as the formation and *separation of an intussusception without symptoms.—Pacific Medical Journal.*

RETENTION OF COIN IN THE ALIMENTARY CANAL FOR NINE MONTHS.—James Kearney, M. R. C. S., reports the following in the *Lancet:*

About ten months ago I was called to see a child aged one year and seven months, who had swallowed a foreign copper coin, slightly larger than a farthing. On my arrival there was nothing in the appearance of the child to indicate anything unusual having occurred. I recommended the mother to feed the child on boiled bread and porridge for the next two days and to watch for the passage of the coin by the bowels. I visited the child on the following two days and was informed that the coin had not passed. I did not see the child again for four months, when I was called to attend it for bronchitis, and was told that the coin had not passed in the interval. I was inclined to conclude either that the coin had been passed without being noticed or that the child had not really swallowed it, but the parents still persisted in saying that the coin was in the "bowels." A few days ago to my surprise I was told by the father that the child had passed the coin, it having been retained in the alimentary tract for nine months and four days. I may say that the child had no convulsions and did not seem to be injuriously affected in any way by the retention.

TRANSFUSION IN PERNICIOUS ANÆMIA.—Dr. D. J. Brakenridge (*Edinburgh Medical Journal*) says:

If all the necessary precautions are strictly adhered to, the operation is perfectly safe.

Quite healthy blood with living blood-corpuscles can be added to the diseased blood of the patient.

This blood exerts a beneficial influnce both on the blood with which it is mixed and on the bloodforming organs, for—

(*a*) Sooner or later the abnormal peculiarities in the forms and the exceptional varieties of the corpuscles disappear.

(*b*) Sooner or later the blood-corpuscles begin to increase in excess of those added by the transfusions.

These facts are opposed to the view that an abnormal destructive activity of a disordered liver is the only or the main pathological condition in pernicious anæmia; for it is difficult, were this true, to understand how the blood-corpuscles added should not soon fall victims to the destructive influence of the liver cells.

The foregoing results of transfusion rather favor, although they do not absolutely shut one up to, the conclusion that the true pathology is, as I have already said, probably somewhat like this:

1. The real condition of the blood in pernicious anæmia is a delicacy and tendency to early death of the red blood-corpuscles.

2. The probable starting point of this delicacy and feeble resistance in the blood corpuscles is some functional weakness in the blood forming organs, which may be due to various possible causes.

3. The irreglar shaped, variously sized, and otherwise abnormal blood corpuscles point to some such imperfect genesis.

4. Consequently, without any abnormally increased destructive force in the portal system and organs—it being a normal function of the liver cells to destroy the red corpuscles—a greatly increased death rate of these delicate and shortlived corpuscles takes place.

5. The introduction by transfusion of a considerable amount of healthy blood acts beneficially in a twofold way:

(*a*) By immediately improving the health and resistance of the blood (including the delicate blood corpuscles) which becomes mixed with it; and

(*b*) Later on, by gradually operating beneficially on the blood forming organs through which it circulates, restoring their blood forming functions to the normal condition.—*Amer. Lancet.*

RENAL COLIC.—Dr. Grasset (*Münchener Med. Wochenschrift*, No. 21, 1893), in renal colic, proceeds as follows:

1. Warm baths of a half to three-quarters of an hour's duration, to be repeated in the evening if necessary.

2. Every hour or half hour chloroform water, 150 grammes (4½ ounces) to 100 grammes (3¼ ounces) of orange flower water and fifty grammes (1½ ounces) of syrup of orange peel—a tablespoonful at a dose. If this does not relieve then give twenty drops of chloroform by inhalation and a subcutaneous injection of a solution of morphine and atropine—morphine one decigramme (1½ grains), sulphate of atro five milligrammes (1.15 grain), and water ten grammes (2½ drachms).

3. If the chloroform be well borne then administer every quarter to half an hour 200 grammes (6½ ounces) of olive oil with essence of peppermint and brandy.

4. A rectal injection containing twenty-five grammes mes (6 drachms) of the sulphate of soda and eight grammes (2 drachms) of senna. As food the patient may take soup and cold milk.

In subacute colic let the patient take a glass of olive oil and each evening a warm bath. Four times a day five to ten drops of the tincture of boldo, as well as morning and evening a pill consisting of one centigramme (⅙ grain) of podophyllin or euonymin, extract of belladonna and powdered belladonna leaves; finally, every two hours, one or two tablespoonfuls of Vichy water, with the addition of a fifteen per cent soda sulphate solution. In the free intervals exercise, cold baths and massage are to be advised. As foods, green vegetables, little sugar, no fatty substances, and but few eggs are to be permitted. For a whole year through he must take for ten days, alternately, a glass of Vichy water and ten drops of tincture of boldo before each meal, and twice a week, in the morning, on an empty stomach, a glass of olive oil. Twice during the year this treatment is to be interrupted and a bottle of Vichy water consumed during the course of the day, in small glasses every half hour, between meals for a month.—*Lancet Clinic.*

THE PERIOD OF INCUBATION OF THE INFECTIVE FEVERS.—The period of incubation of the various infective fevers has been a matter of great discussion, and one concerning which definite conclusions have not been reached. A report on this subject by a com-

mittee of the London Clinical Society will be received with much interest.

The material which the report contains was obtained in response to a circular letter issued in 1889 by a committee over which Dr. Broadbent presided. The large mass of documents received was digested by Dr. Dawson Williams, one of the honorary secretaries of the committee. Dr. Williams was at the pains to go through the whole of the reports made by its medical inspectors to the Medical Department of the Local Government Board since 1878, which had been laid open to the inspection of the committee by Sir George Buchanan, one of its members. Many important facts and observations, in respect especially to diphtheria, typhoid fever and scarlet fever were thus obtained.

The system upon which the summaries were prepared has been to take first those cases in which the exposure to the source of infection was for a short time—a few minutes or hours—at a known date. These have been made "the basis of the conclusions drawn as to the duration of incubation; while other histories, in which only the date of the commencement or cessation of exposure to a source of infection was given, have been used for contributory evidence." The duration of infectiousness is also investigated by the light of the data supplied; and the length of time which a patient who has suffered from the disease should be isolated, the period during which a susceptible person exposed to infection should be quarantined, the liability to the retention of infection in clothes and to its dissemination by milk and water, are also considered.

The conclusions of a committee which has evidently gone over the subject so carefully are of much importance, and deserve to be presented here:

Diphtheria, two to seven days; oftenest two.

Typhoid fever, eight to fourteen days; sometimes twenty-three.

Influenza, one to four days; oftenest three to four.

Measles, seven to eighteen days; oftenest fourteen.

Mumps, two to three weeks; oftenest three weeks.

Rubeola, two to three weeks.

Scarlet fever, one to seven days; oftenest two to four.

Small-pox, nine to fifteen days; oftenest twelve.

Further investigations were made with regard to the time and duration of the infective period.

Diphtheria was found to be infective during the period of incubation, attacks and convalescence.

Mumps and rubeola are also infective for three or four days before the onset of the parotiditis and appearance of the rash.

The contageousness of measles speedily disappears and does not continue in disinfected persons for over three weeks.

Typhoid fever is infectious from the time of onset until two weeks after the fever has gone and convalescence set in.

As is well known, the contageouness of scarlet fever varies greatly, but is generally continued a very long time—certainly until desquamation ceases, and sometimes as long as eight weeks—*N. Y. Med. Record.*

Therapeutics.

ANTIPYRINE.—Dr. Perdriel (*Medicinische Neuigkeiten*, No. 7, 1893) advises prescribing antipyrine with the bicarbonate of soda and tartaric acid, in capsules, as thus the nascent carbonic acid prevents the antypirine from disturbing the stomach in sensitive persons.—*Lancet-Clinic.*

A NEW METHOD OF RESUSCITATION IN CHLOROFORM NARCOSIS.—The *Zeitschtift fuer Geburt, und Gynakol* gives a synopsis of a report made by Winter to the Obstetrical and Gynæcological Society in Berlin, of the method recently employed in Konig's clinic at Gottingen for restoration in cases of apparently fatal chloroform narcosis. Maass, an assistant of Konig, treated a severe case successfully by it. The patient had been worked over for an hour without any result; respiration and pulse had entirely ceased, but by rapid, rhythmical compressions (about one hundred and twenty per minute) of the cardiac regions, the heart's action gradually increased, and the patient recovered. A second case responded in a similar manner. Maass ascribes the effect of the cardiac compressions to driving the blood into the larger arteries, as, with each compression he could detect a synchronous weak pulse in the carotids. Winter reports another case in which he tried the method. The patient became asphyxiated before the operation, and respiration ceased but was restored by artificial respiration. She breathed regularly, and the color of the face was normal, but the heart ceased absolutely, no pulse could be felt or heart sounds heard, the respiration became slower, and superficial and slight cyanosis appeared. At this stage, Winter employed Maass's compressions rapidly and energetically about twenty to twenty-five times, when the pulse gradually improved, respiration commenced, and the asphyxia disappeared. He believes it a valuable method of restoring asphyxiated children after birth. Olshausen and other members of the society, expressed themselves in favor of this method.—*Amer. Surg. and Gynecol.*

SOME NEGLECTED POINTS IN THE DIET OF A DIABETIC.—It is a trite theraupeutic maxim in diabetes that by withholding starchy and saccahrine foods the urine of the patient is made to present less sugar in the test tube. From this result an improvement of the patient is argued. In many instances this is a correct deduction, but there are other elements in a case of diabetes which demand consideration and which the mere reduction of sugar in the urine does not meet. The chief element of importance in the management of diabetics is the necessity of keeping the general health at as nearly a normal standard as is practicable. For this purpose attention to a general hygiene, systematic exercise, bathing, freedom from care and excitement, regular hours, are quite as important as the dietary restriction. It becomes specially important to be cautious with the latter when we have a severe case of diabetes to deal with. Under ordinary conditions in other diseases severity of type would be an indication to greater stringency in the means adopted. In diabetes, however, the experienced physician will be wary in reducing the patient's supply of amylaceous food and limiting him to albuminous nutriment, when he is in the presence of a case that presents a large percentage of sugar in the urine, and especially when great muscular weariness exists. Many a diabetic has gone into a coma after being intimidated into dietary overcaution. It is far better in these cases to allow a moderate quantity of starchy food, and endeavor to counteract its

probably deleterious effect by gentle muscular exercise and massage if the patient is very feeble. Rapid respiration has been to the writer a warning symptom to beware of insisting on a pure albuminous diet. Called to a case of facial erysipelas, in consultation, the writer surprised the attendant by advising an entire abandonment of the strict diet, which then consisted chiefly of beef tea and had been strictly albuminous for many months. When the attendant remonstrated that this diabetic lady had a large percentage of sugar in the urine, demanding imperatively dietary restriction, he was reminded that she was rapidly sinking under the treatment pursued and certainly could not be made much worse by a change. Barley and rice soups were administered. The patient relished them and in a few days was thus tided over the danger whose imminence demanded a consultation. When she was convalescent the antidiabetic diet was resumed and she lived several years afterward.

In mild and early cases of diabetes greater strictness of diet may be enforced with advantage. But in these also attention to systematic exercise, daily measured if need be, will contribute greatly to the utilization of sugar within the interfibrillar muscular fiber. We thus not only aid in disposing advantageously of sugar that would otherwise be eliminated in the urine, but we further the maintenance of the general health, which is the great guiding principle in the therapeutics of diabetes.—*Jour. of Balneol.*

Mechanical Treatment of Chronic Rheumatism.—Dr. C. O. Walbridge recommends mechanical means, including calisthenics with its healthful exercise of body and limbs, to break up existing adhesions, to smooth the roughened articular cartilages, strengthen the contracted tendons and nerve tissues, and restore the joint to its former suppleness—first, by a process of stroking and kneading in a centripetal direction, stimulating the lymphatics and venous currents and surrounding tissues to greater activity, carrying the lymph with greater rapidity toward the center. By these means the lymphatics and circulating system are stimulated, setting up changes in the nutrition, causing healthy activity in the parts. In cases where there is perceptible defective nutrition, constitutional remedies with dietetic medication must be employed. The primary effects are upon the joints, muscles, and nerves. In the joints stiffness, adhesions, and contracted tendons are broken up and got into a proper condition for absorption. The secondary effects are produced upon the circulation and lymphatic system, The muscles and nerves are surely elongated, heat must necessarily be evolved by the manipulations changing the molecules of the muscles from an inactive to an active state, causing internal work, setting up molecular changes in all of the surrounding tissues. The waste material is carried away by increased action of the lymph and circulation, and new nourishment is more readily carried to all parts, feeding them and enlivening the whole organism.—*The Dietetic Gazette.—Jour. of Bolneology.*

The Therapeutics of the Hot Bath.—Baelz, of Tokio, reported to the Medical Congress at Wiesbaden (*Münch. med. Woch.*, May 2) the results of a study of the hot bath made in Japan, where it is much resorted to by all classes of the population. The bath is often taken at a temperature as high as 106° F. The hot bath causes a rise of the body temperature to as high as 104 to 106° F.; this is due to absorption of heat, not to storage. The frequency of the pulse is increased, and the vessels dilate, losing their elasticity. The hot bath does not weaken or depress. It does not favor "catching cold," as does the warm bath (98° F. or less). On entering the hot bath hot water must be poured on the head to prevent cerebral anæmia. The hot bath is a derivative remedy, and is indicated in capillary bronchitis and lobular pneumonia. Three or four general baths should be given daily. The hot bath is also of use in rheumatism, nephritis, and at the onset of menstruation when accompanied by uterine colic. Baelz affirmed that at the baths of Kusatsu, where the water contains sulphates and chlorides, the Japanese took daily five baths of three minutes' duration, at a temperature of 129° F. (54 C.) After six days an exanthem is produced which resists all treatment, but eventually disappears spontaneously. The baths of Kusatsu are used in the treatment of severe chronic rheumatism, of gout, and of obstinate syphilis, as well as of leprosy.—*British Med. Journal.—Lancet-Clinic.*

Nitroglycerine for Vomiting.—Humphries (*British Med. Journal*, No. 1683, p. 693) reports having employed nitroglycerine systematically for three years in all forms of vomiting encountered, with highly satisfactory results. In cases of gastric catarrh, in the adult or in the infant, acute or chronic, dependent upon alcoholism or upon anæmia, it acted almost as a specific. It also proved useful during pregnancy. In peritonitis alone it increased the vomiting, but the effect soon passed off. It proved of little value in the relief of the vomiting of pulmonary tuberculosis. In combination with catechu it acted well in several cases of lienteric diarrhæa. The vomiting of influenza was also relieved by the use of the agent, which was in no instance attended by bad results.—*Med. News.*

The Antidote for Arsenic.—Dr. Squibb recommends the following as a simple method of preparing hydrated oxide of iron, the antidote for arsenic, one of its chief advantages being that the ingredients are always easily obtained: Take of tinct. ferri chloridi, four ounces; aqua fort. four ounces; mix in a vessel of twelve ounce capacity, and add aqua ammon., one drachm. Shake well, pour it on a large wet muslin drainer, wring out the water and alcohol and wash with fresh water. The stomach having been evacuated by emetics, while the antidote was being prepared, give four fluid ounces at once, to be followed by an emetic. Then give two ounces every ten minutes.—*N. Y. Med. Times.*

A Lininment for Excessive Sweating of the hands.—The following formula is attributed to the *Journal des sciences medicales de Lille:* Borax and salicylic acid, each, fifteen parts; boric acid, four parts; glycerin and alcohol, each, sixty parts. The hands are to be rubbed with the liniment three times a day.—*N. Y. Med. Journ.*

Bromoform in Pertussis.—Dr. Charles G. Kerley reports the following in the *Arch. of Pediat.*—Three children aged respectively eight, six and four years, members of the same family, developed pertussis within a few days of each other. They came under my observation at the Babies' Hospital at the onset

of the disease, in fact, before the diagnosis was absolutely positive. Pertussis was strongly suspected, however, and they were put on the bromoform treatment at once, which drug has been used in the management of this affection by many observers with widely varying results. It is claimed by some that if bromoform is given early, the disease may be aborted, by others that the number and severity of the paroxysm will be diminished, and the duration of the attack shortened. Equally good observers, on the other hand, state that after a fair trial the drug proved itself valueless in their hands.

Concerning the cases in question the youngest, a decidedly rachitic girl of four years, was given five drops four times daily; the other two, fairly healthy boys, each received six drops four times daily. Under the treatment the disease developed apparently about equally severe in all. The paroxysms varied from fifteen to twenty daily; vomiting occurred frequently during the second week, during which time the disease was most severe, the patients presenting the typical appearance; the eyes congested and the faces puffed and swollen. At about the eighteenth day of treatment the disease began to subside, the number and severity of the paroxysms diminished rapidly, the vomiting ceased and at the end of the fourth week, greatly to my surprise, they were practically well as far as the pertussis was concerned.

Heat and Chloroform.—Decomposition of chloroform by the presence of light and heat from an open fire, not infrequently occurs and is disagreable to operator, assistants, attendants and patient. Little has been known about the matter until the *Medical Press and Circular* in a recent issue called attention to the danger. In December last, in this city, during an operation for hemorrhoids, chloroform being the anæsthetic employed, the operator, anæsthetizer and attendant began to cough violently; this was accompanied with irritation and watering of the eyes and a dry and irritated throat, and a strong and pungent odor of free chlorine was noticed. The cough and discomfort in eyes and throat continued for a considerable time after leaving the operating room. It was supposed that the chloroform was impure, and the bottle with what remained of its contents was sent to the manufacturer, Dr. Squibb, of Brooklyn, who reported, after analysis, that it was entirely pure. It was then remembered that, as it was a cold day, an oil heating stove had been burning during the operation. This fact Dr. Squibb considered as the cause of the decomposition of the chloroform with evolution of free chlorine. The patient in this case suffered no discomfort whatever.—*Med. Review.*—*Med. and Surg. Reporter.*

Epilepsy.—Prof. Flechsig, of Leipzig, treats epilepsy by first giving opium in increasing doses, and following it by bromide of potassium. He begins with the daily dose of ⅛ grain of extract of opium, and progressively runs the dose up to twelve or fifteen grains, given at three times. At the end of six weeks he abruptly suspends the opium and begins with bromide of potassium in the daily dose of two drachms, which he continues for two months, and then gradually diminishes the quantity to thirty grains daily. The opium is said to render the system very sensitive to the action of the bromide.—*La Riforma Medica.*

Belladonna in the First Stage of Labor.—When, notwithstanding persistent pains, the os uteri does not dilate sufficiently (especially if the patient be a primipara), Asher recommends the administration every hour, or at shorter intervals, of twenty to thirty drops of the tincture of belladonna (never less than twenty drops). In numerous cases in which he tried this treatment the results were always excellent—rapid diminution of the pains, energetic dilatation of the os. Belladonna is superior to chloral. —*Internat. Med. Mag.*

Scopalamine Hydrochlorate; A New Mydriatic.—This alkaloid is obtained from the root of *Scopolia atropoides*, and, like atropine and hyoscine, belongs to the group of tropeines. The results of Rahlmann's study of this drug are reported in the *Klinische Monatsblätter f. Augenheilkunde* for February, 1893. Previous experiments by Kobert had shown that scopalamine had an opposite physiological action to atropine in that it did not stimulate the cerebral cortex, but paralyzed it; and did not accelerate the pulse, but retarded it. According to Rahlmann, scopalamine as a mydriatic and antiphlogistic is superior to atropine and all other tropeines. In its mydriatic strength it resembles hyoscine, but it does not possess the disadvantages of that drug. Unlike atropine, it does not disturb the appetite, nor, except in very large doses, does it cause dryness of the throat; it does not produce nervous restlessness, flushing of the face, or quickening of the pulse.

The remedy is superior to atropine in influencing pericorneal injections and pannus, and is of special advantage in supperative inflammations of the anterior section of the eyeball. In five cases it caused a steady diminution of an hypopyon. It does not affect intraocular pressure, and may, therefore, be employed instead of atropine when the intraocular pressure is increased. For this reason the drug is of great value in inflammatory affections of glaucomatous eyes.

Hydrochlorate of scopalamine is five times as powerful as atropine, and may be employed in 1.10 to 1.5 per cent solutions. The duration of the effect is about the same as atropine. It acts best in divided doses.—*Univ. Med. Maga.*

The Therapy of Lepra.—Danielssen reports (*Ergänzungshefte zun Archiv f. Dermatologie u. Syphilis*, I Heft) thirteen cases of leprosy treated by the method claimed by Unna to have been curative in several cases. This treatment, which consists in the external and internal employment of chrysarobin, salicylic acid and creosote, together with the internal admininistration of ichthyol, was employed in the tubercular, anæsthetic and mixed forms of the disease, but without obtaining the result claimed for it by its author. Although some of the nodules were absorbed, new lesions arose to take their place, and no permanent improvment followed the treatment. As the writer points out, there are many methods of treatment by which temporary disappearance of the cutaneous lesions may be brought about, without, however producing a real cure. Trial was also made of hydroxylamin externally, of europhen by hypodermic injection, and of aristol, hypodermically and externally, without favorable result.—*Univ. Med. Maga.*

Treatment of Odontalgia by Electricity.—Dr.

G. Gatchkovsky (Rybinsk), a Russian physician who has given a good deal of attention to the study of electrotherapeutics, has observed that the pain of toothache is readily soothed by the application of electricity. The current is made to pass through the painful part by pointing the electrode toward it while the patient is placed in communication with an electro-static machine. During the operation the patient is seated on a stool, the feet of which are made of nonconducting material, such as is commonly used for purposes of franklinization.

According to Dr. Gatchkovsky, the electricity developed by the static machine is anodyne not only to toothache of a purely neuralgic character, but also to that which is due to inflammation of the pulp or to periostitis. The pain is sensibly less two or three minutes after the application is commenced, and entirely disappears in four or five minutes. It sometimes returns after a variable interval of complete relief, but it is then much less severe, and is easily and definitely cured by a few more sittings, which should each last for at least ten minutes.

Dr. Gatchkovsky has also noticed that at the same time as the pain disappears the gums become extremely pale.

This treatment has now been tried in seventy-six cases, with only three failures.—*La Semaine Medical.—Jour. of Balneol.*

Lactic Acid in Diarrhea.—N. V. Lojkin draws uttention to the great value of this medicine in chronic dysentery and acute dyspepsia. He reports a case in which several drugs had failed to cure chronic dysentery, but which was entirely cured in nine days by administering half a tumblerful of a two per cent solution of lactic acid twice daily. The blood disappeared from the stools in a day or two. Another case, one of acute dyspepsia, he reports as being cured in twenty-four hours, only two doses having been given.—*American Therapist.*

New Remedies in Gonorrhea.—Jadasson (*Deutsche medicinische Wochenschrift*, 1892, Nos. 38, 39) speaks of the value of ichthyol in gonorrhea in women as well as men. He obtained excellent results in thirty-seven cases of gonorrhea in females. In men, uncomplicated cases were in the forms most favorably influenced. As he obtained such good results in specific urethritis, he was led to employ the remedy in gonorrheal catarrh of the cervix. The drug may be applied readily to the cervix, and later to the endometrium, with an ordinary Playfair's probe covered with wool; a 10 per cent ointment is sufficient. The probe may also be used for the urethra, employing a weaker preparation—from 1 to less than 10 per cent. In some cases it may be injected, or the urethra packed with gauze dipped in the icthyol, and introduced through a urethral speculum.

Caspar (*Berliner klin Woch.*, March 27, 1893) reports twelve cases of acute gonorrhea treated by an injection of a 1 to 2 per cent solution of alumnol administered thrice daily. In seven of the cases a cure was effected at the end of first six weeks. In the other five cases the gonorrhea became chronic.

In eight cases of chronic gonorrhea the treatment consisted of a 1 to 2 per cent alumnol solution applied by Guyon's method of instillation. One case was cured after four instillations. In the other seven the secretion was unaffected or worse after ten instillations. He believes that in acute gonorrhea alumnol is neither inferior or superior to other remedies in common use, and that in chronic gonorrhea it is inferior to nitrate of silver.

In twelve cases of simple chronic urethritis alumnol proved inferior to nitrate of silver. Caspar agrees with Chotzen that the injections do not cause pain and never lead to cystitis. In two cases of chancroid alumnol effected a rapid cure.

Grovtzoff, of Sebastopol (*Medit. Probat. klin Morsk. Slomiki*, 1892, No. 9), has obtained excellent results with salol in gonorrhea. He employs the drug in doses of one gramme to one gramme and a half, which he repeats three or four times daily, and claims that he obtains therapeutic effects in from four to five days.

In subacute cases he associates cubebs with the salol, administering the two in capsules. In addition to the internal medication he employs the following solution of salol:

℞ Salol, 10 grammes.
Pul. acaciæ, 5 grammes.
Aquæ destil, 2,000 grammes.

The injections should be repeated three or four times daily.—*Univ. Med. Maga.*

The Treatment of Ringworm of the Scalp.—Eddowes (*British Medical Journal*, April 15, 1893) recommends the following method of treatment as being efficacious in this intractable disease:

During the first week a sulphur ointment is applied daily, the hair having first been cut short. The scalp is to be washed two or three times during the week with soap and water, and a cap is to be worn continuously.

In the second week an ointment containing twenty-five grains each of chrysarobin and ichthyol, and ten grains of salicylic acid, is to be thoroughly rubbed into a few of the patches, the sulphur ointment being applied to the rest of the scalp. After each application the ointment is covered with oiled silk or guttapercha tissue, kept in place by a skull cap. If this chrysarobin ointment is well borne, the area to which it is applied is increased daily until it is used over the entire diseased scalp, but never for more than four days in succession. At the end of four days, or, if considerable irritation arises, sooner, the chrysarobin ointment is suspended, and the sulphur used in its place. At the end of the second week the scalp should be thoroughly oiled at night, and washed next morning with soap and water. The combined use of these two ointments is to be continued in the above manner until a cure has been obtained.

Points of importance are: 1st. Thorough cleansing of the scalps before using the chrysarobin; 2d. removal of secretion and scales with the sulphur ointment before reapplying the chrysarobin ointment, which latter should only be done after the skin has returned to its normal color.—*Univ. Med. Mag.*

Treatment of Influenzal Pneumonia.—Huchard (*Sem. Med.*, Feb'y 13, 1893,) recommends the prescription of digitalis at an early date in the treatment of this form of disease. He recommends its early use and not to delay until the heart shows signs of failure. He prefers digitaline. He uses a solution of crystallized digitaline in water (1 to 1,000); of this solution he gives a single dose of forty or fifty drops, containing about 1-55 grain. He considers it useless

to give the drug in repeated doses at short intervals, as the action is equally well obtained and maintained by a single large dose. The only food given is milk, which he believes favors the action of the drug. He gives no medicine the day after this dose of digitaline is given, unless cardiac adynamia is very profound. Then he gives subcutaneous injections of caffeine, ether or camphor. The solution for subcutaneous use is thus composed: Sterilized olive oil, 100 parts; camphor, ten parts. Give the injection two to four times a day. If necessary, the digitaline may be given for seven or eight days, but the dose should be reduced to twenty or thirty drops.

Huchard believes in rendering the mouth and intestinal canal aseptic. For the former, he uses a solution of bichloride, but suggests that oxygenated water would be equally effective. The washings should be frequently repeated to prevent secondary infection of the air passages. For intestinal antisepsis he prefers benzo-naphthol, given in capsule four or five times a day. If the asthenia continues in spite of ether, camphor or caffeine, he prescribes subcutaneous injections of strychnine sulphate, in doses of 1-30 to 1-60 of a grain. In all cases of influenzal pneumonia, he gives from one to two drachms of tincture of kola and tincture of coca, equal parts daily.—*Am. Therapist.*

Petroleum in Diphtheria.—Flahant (*Normandie Med.*, No. 3, 1893) gives particulars of an epidemic of diphtheria at Neuville-Champ-d'Oissel, in 1891–92, in the course of which seventy persons were attacked. He treated thirty cases by the common methods with the result that nine died and twenty-one recovered. These cases were treated between April 15, 1891, and May 5, 1892. From the latter date until June 5, 1892, he treated forty cases with petroleum without a single death. There was no mistake in the diagnosis.

There is neither difficulty nor risk in the treatment. The throat should be painted every hour or every two hours with a brush steeped in crude petroleum. Shake the brush gently before using it, so that there may be no excess of liquid to trickle into the respiratory passages. There is no pain, even when the mucous surface is raw and bleeding. Immediately after the application, the membranes separate and dissolve. A fortnight after the adoption of the method the epidemic ceased.—*American Therapist.*

Creasotal in Tuberculosis.—Brissonnet (*Rep. de Pharm.*, Feb. 10, 1893) reports that by acting upon creosote with carbonic acid, a neutral body is produced with a bland, oily taste, without odor; it is non-irritating, to mucuous membranes and capable of being absorbed in large doses without disturbing the stomach. This new body, to which Brissonnet has given the name of creosotal, is as active as an equal weight of creosote. Creosotal is a viscid liquid at the ordinary temperature, but becomes quite fluid under the influence of even a moderate amount of heat. Its specific gravity at 15 deg. C., is 1,165; it is insoluble in water, glycerin and weak alcohol but soluble in all proportions in alcohol at 95 deg., ether, chloroform and benzine. It does not disturb the digestive functions, even in doses of ten, fifteen or twenty grams per diem. It is decomposed in the intestine into its components, creosote and carbonic acid, and creosote may be found in the urine half an hour after the ingestion of its carbonate. Creosotal has been used with success in the treatment of tuberculosis.—*American Therapist.*

Surgery.

Cause of Cancer.—Dr. O'Sullivan (*Australian Medical Journal*) says:

Whatever produces chronic ill-health depresses the nervous system, and is clinically found to constitute an influence strongly predisposing to cancerous developments generally.

Local agencies exert only a minor influence in their direct genesis.

While rapidly increasing in prevalence in civilized nations, they are almost absent among the savage.

Malignant disease is in very many instances primarily local and due to disordered functions, as proved by the fact known to all surgeons, that the disease when promptly removed may never recur.

Benign ulcerations may become malignant, when it may be assumed the phagocytic action of the leucocytes has become subjugated by the microörganism.

Disease of any kind, whether malignant or inflammatory, never occurs in an individual whose functions and nervous system are in perfect health, and who has, as a consequence, perfect local and general resistance to all pathogenic microörganisms—in whom phagocytosis is healthily and perfectly accomplished. (And here I may be allowed to say that Mr. Jonathan Hutchinson insisted that cancer is simply a modification of what occurred in chronic inflammation.)

When, from continued irritation, depressing influences, or advancing age, the physiological character and vitality of the animal cells become lowered, cancer finds all the conditions necessary for its growth.

In a word, cancerous disease is but one of the many proofs of overpressure on the nervous system, which the artificial and vicious conditions of modern civilization involve.—*American Lancet.*

Abscess of the Cerebellum Consecutive to Otitis.—L. G. Jourdanet (*Thèse de Lyon*) states that lesions of the cerebellum resulting from otitis are much less frequent than are those affecting the meninges and the cerebrum, hence less noted by aurists and general surgeons. According to Jourdanet's investigations, chronic suppurative otitis media gives rise to abscess of the cerebellum in the proportion of three in every ten cases of otitis encephalic abscess, *i. e.*, 30 per cent of all cases. Abscess of the cerebellum is more likely to occur in the adult than in the child, because of the absence in the latter of well-developed mastoid cells.

A remarkable exception to this rule was the case reported by Burnett (*International Med. Journal*, Philadelphia, August, 1892), observed by him, and operated on by Keen. In this instance the abscess was the result of an acute otitis media.

Abscess of the cerebellum may coexit with those in the cerebrum in the proportion of 5 per cent. They are generally solitary, being sometimes in direct communication with the original lesion, and sometimes separated by a layer of healthy tissue. They are usually of some duration when the autopsy is made, and they may be accompanied by thrombosis of the sinuses, basic meningitis, visceral lesions, etc., which contraindicate surgical interference. Diagnosis is

extremely difficult. Generally, the surgeon is led to penetrate the cerebellum, after a fruitless trepanation in the region of the temporo-sphenoidal lobe.—*Am. Jour. Med. Sciences.*

TAPE-WORM THE CAUSE OF RUPTURE OF THE INTESTINE.—Dr. F. Dunlap (New York *Medical Journal*) mentions a case of intestinal rupture occurring in a woman of thirty-one years of age, apparently caused by a tape-worm. When first seen the patient complained of violent pains in the left iliac region, followed in several hours by profound collapse. Rupture of an ectopic pregnancy was suspected, the suspicion being encouraged by the fact that menstruation had been absent for several months. A boggy mass was to be felt in the abdomen, and abdominal section was decided upon and performed. A mass of clot was found in the pelvis, but the pelvic organs were found in a normal condition; nor could any aneurism, which had been thought of, be found. In flooding the cavity a long tape-worm was floated to the surface, and tracing it toward the head, it was found to protrude from a large, ragged rupture in the small intestine. It was fastened about twelve inches above the seat of rupture. Eight feet of the worm were removed from the peritoneal cavity, and about seventeen feet more were passed from the bowel afterward as the result of an enema. From examination it appeared that there had existed no previous ulceration at the site of the rupture, the ragged gangrenous edges suggesting rather a pressure gangrene. The patient recovered.—*Intern. Med. Magazine.*

TONSILLOTOMY TO PREVENT DIPHTHERIA.—In a recent article in the *Journal des Sciences Medical de Lille*, Lancey advocates a procedure the common sense of the profession should have established long ago. Reasoning from the well-known fact that a great majority of all cases of diphtheria start on the tonsils, he advocates their removal, when enlarged, to prevent the lodgment of the bacillus. The Loeffler bacillus is aërobic. If swallowed it would die from lack of oxygen and from the action of the gastric juices. Lodging in the crypts of a projecting tonsil, it is in the best possible position to grow. The tendency to enlarged tonsils is hereditary. When one child of a family where all the children have enlarged tonsils contracts diphtheria, the others run much greater risk of contracting the disease than they would with normal throats. This risk can be greatly reduced by removal of the tonsils. Recurrent attacks of follicular tonsillitis are best treated in the same way. The tonsils should be amputated in the interval between two attacks.—*Lancet Clinic.*

THE TREATMENT OF SEVERE CLUBFOOT. (*Brit. Med. Journ.*).

Conclusions:

1. That in the treatment of severe cases of clubfoot in the infant our aim should be to act on the bones rather than merely to stretch or divide the soft structure on the inner side of the foot.

2. That to accomplish this object the varus defect must not be too quickly overcome.

3. That when the varus is cured the foot should, if possible, be carried at once after division of the tendo-Achillis beyond a right angle with the leg, there being no danger of nonunion of the tendo-Achillis.

4. That when the foot, after division of the tendon will not come up to or beyond a right angle it is the result, not, as a rule, of contraction of the posterior ligaments or of the astragalus being partially tilted out of its socket, but of a downward deflection of the astragaloid neck.

5. That attempts are best directed to overcome this deflection by acting on the bone rather than by division of the posterior ligaments or soft structures in the sole of the foot.

6. That in exceptional cases, even in the infants, we can prognosticate from the first that neither the varus nor the equinus will be thoroughly overcome without a bone operation.

7. That for such, but only after all gentler means have been perseveringly tried, and for confirmed cases in older children, astragalectomy, with, if necessary, the removal of a further portion or portions of the tarsal bones, is on the whole, the best operation.—*Arch. of Pediat.*

A LARGE TUMOR OF THE FACE GREATLY REDUCED IN SIZE BY INJECTIONS OF METHYL BLUE.—Dr. Lindner (*Wiener Med. Presse*, No. 8, 1893) observed a large tumor occupying the left temple, the zygomatic region and cheek, which had been growing for about a year. It was somewhat elastic, without fluctuation or nodules, and not displaceable. It was diagnosticated as a probable malignant sarcoma, springing from the bone or periosteum. It was treated with injections of methyl blue, according to Mosetig's method, with results that might be called wonderful. It has diminished three-fourths in size, and the ulcers have healed over. The mass, which was elevated some three centimeters over the surface of the face, is now scarcely perceptible. The injections were made every few days at various points of the periphery. They produced great swelling and œdema, and once an abscess. In four weeks the tumor was one-third smaller, and now it is about one-fourth the original size. In the last four weeks since the patient was discharged the reduction has still continued. This was an undoubted case of malignant neoplasm. Syphilis could be excluded. In inoperable malignant tumors he recommends giving this procedure a trial. —*Pritchard, in Lancet-Clinic.*

THE USE OF AMBULATORY DRESSINGS IN FRACTURES OF THE THIGH AND LEG AS WELL AS IN COMPLICATED FRACTURES.—Korsch (*Berliner klinische Wochenschrift*, January 9 1893) describes the method in use in Prof. von Bardeleben's clinic of treating fractures of the lower extremities when the patient is allowed to walk. The use of padding underneath the plaster of Paris dressing is objected to. The author says it soon loses its elastisity, becomes impregnated with sweat, and the plaster thus becomes loose, and displacement and excoriations are apt to occur. He advocates the return of the procedure of von Adelmann of fifty years back to anoint the skin with some fatty material, and apply the plaster directly thereon. In applying a bandage to the leg the knee is bent and the foot held at a right angle. When a change in the direction of the bandage is desired, it is cut with a pair of scissors and reapplied instead of reversing. This avoids the formation of folds. To strengthen it pieces of leather —shoemaker chips—are inserted. The bandage is allowed to remain on from ten to fourteen days. Fractures involving the ankle are treated on a Watson splint, and moist compresses applied for eight days.

They are then put in plaster, which is changed every eight days. In compound fractures, if not severe, the plaster bandage is applied in a couple of days; if more severe in six or seven days. The wound is tamponed with iodoform gauze, and brought together with silk sutures, one end of the gauze being allowed to protrude; additional gauze is then applied and the plaster dressing put on over all. In fractions of the femur the patient is kept in bed for seven or eight days and twenty-five pounds extension applied while the limb is retained in an abducted and elevated position. The patient is then placed on a table provided with a Bardeleben pelvic supporter, and a plaster bandage applied to within four inches of the tuberosity of the ischium. A padded ring, with two side irons, like a Thomas splint is then pressed firmly up on the tuberosity. The two side wires are then brought down the leg, past the knee, and along the sides of the foot. The whole is next covered with additional plaster bandages. The patients are allowed to go about on crutches twelve hours after the application of the bandages.—*Univ. Med. Magazine.*

THE PATHOGENESIS OF BURNS.—In "A Contribution to the Pathogenesis of Burns" (*Ergangungshefte zum Archiv f. Dermatologie und Syphilis*, I Heft, 1893), Reiss expresses the opinion that the clinical phenomena observed in cases of severe and fatal burn are due to the absorption of pyridin and its compounds, which are produced by the action of heat upon the skin and underlying tissues. Chemical analysis shows the presence of these substances in the urine of patients suffering from burn; and in animals poisoned by it experimentally anuria, somnolency and vomiting are produced, symptoms often observed in extensive burns.—*Univ. Med. Maga.*

A NEW MEHHOD OF SURGICAL TREATMENT FOR TONSILLAR HYPERTROPHY.—Ruault, in *L'Union Medicale*, January, 1893, describes his method of removing hypertrophied tonsils. He claims it is superior to both the tonsillotome and ignipuncture in cases where such methods are usually employed. It does not cause bleeding like the former, nor pain, either immediate or consecutive, as does the latter. It enables one to operate with a precision and surety lacking in other methods. Cocaine having been applied to the tonsil any crypts containing concretions are cleaned out, and such adhesions as may exist between the tonsil and soft palate destroyed. By means of a cutting forceps, one blade of which is flat and fits into the opposite one, which has a sharp cutting edge, small pieces of the projecting tonsil are then removed. After several pieces have been cut off, the raw surface is energetically rubbed with a swab of cotton moistened with iodine one part, iodide of potassium one part, and water six to eight parts. The discomfort arising from this passes off in a quarter or half hour. In a few days secondary retraction will have reduced the size of the remainder of the tonsil, and, if necessary, any projecting pieces may be removed as before. Of eighty cases treated by the author in only three was there a necessity of operating a third time, except in the case of infants.—*Univ. Med. Maga.*

THE PRESENT STATUS OF THORACIC SURGERY.—At the meeting of the American Medical Association, Dr. J. McF. Gaston read a paper of this title which contained the following summary:

1. All penetrating wounds of the thorax may be closed hermetically by suture after allowing the discharge of fluid blood from the opening.
2. Foreign bodies lodged in the bronchi may be removed by incision of the trachea at the lowest available point.
3. Experiments for reaching the bronchi through the chest wall afford little encouragement in undertaking operation upon the human subject.
4. Medication as a preventive and curative agency in pleuritic effusion is worthy of trial before recourse to operation.
5. Aspiration is indicated when there are large serous accumulations, and likewise in pneumothorax, but cannot be relied upon for the relief of purulent collections.
6. Partial resection of ribs is attended with better results in some cases of empyema than the complete removal of the segments of several ribs.
7. The excision of a small portion of one rib, with the introduction of drainage tubes, has been generally attended with good results.
8. Washing out the cavity of the chest is not requisite, except in case of contamination and decomposition of the contents.
9. The operation of thoracotomy for abscess and gangrene of the lung should be accompanied with antiseptic applications and with gauze tamponage.
10. Tumors of the mediastinum admit of interference, but further improvements are requisite.

ABSCESS OF THE PANCREAS.—Dr. Whitton describes the case of a man who had fallen from his dray in a state of intoxication, and was admitted to the hospital with four ribs broken. Next day there was some tympanites, and he was coughing a good deal. The third day he began to vomit a bilious fluid, and complained of a fixed pain just above the umbilicus. For a week the patient's condition fluctuated, the vomiting and pain being the chief symptoms, though neither of them was constant. At the end of this time he seemed worse. There was some diarrhœa, when at 3 P. M. he began to vomit yellowish fetid pus, and gradually sank, dying at eight o'clock the same day. At the post mortem some recent pleuritic adhesions were found on the right side in the neighborhood of the fratured ribs, and the liver was friable; but the chief result was the discovery of an abscess in the pancreas, penetrating the duodenum about eight inches from the pyloric end of the stomach.—*Australian Medical Gazette.—Pract. and News.*

PARTIAL RESECTION OF THE URETHRA WITH IMMEDIATE RESTORATION.—Guyon (Gaz. hebdom de med. et de chir., 1892, November 20.) The floor of the urethra is the principal, if not the exclusive seat of disease and injuries, particularly chronic inflammation. The upper wall maintains its integrity in the majority of instances. In case of total resection a great disadvantage results from the recession of the urethral ends. Partial resection, in addition, presents some advantages in the final effect. Guyon emphasizes the fact that it is not absolutely necessary, in order to obtain a new urethra to unite urethral tissue to urethral tissue. The soft parts of the perinæum may be employed with very satisfactory results. A urethra formed in this manner, according to Guyon, is to be preferred

to one with greatly retracted cut ends. He considers the dangers of urinary infiltration as so small that he no longer drains, as was the former custom, the anterior portion of the wound by means of a strip of iodoform-gauze, but closes the former at once. In cases favorable for the procedure, the soft parts are separated or excised, following which a crucial incision is made in the diseased portion of the urethra.

By this means the limits of the urethral disease may be recognized, both by the eye and finger, and the condition of the upper wall particularly, ascertained. After excision of the diseased portion, if the tension is not too great, the gap in the floor of the urethra is closed at once by a transverse line of sutures in a single layer. In suturing the perinæum, catgut is used for the deeper portion and silk-worm gut for the outer. A rubber catheter is kept in position from two to four days. Six cases are reported, in four of which complete restoration was successful upon the first trial.—*Brook Med. Journal.*

Present Status of Drainage in Surgery.—In a paper read before the Southern Surgical and Gynecological Society, Dr. A. M. Cartledge, of Louisville, presented the following conclusions:

1. To lessen the use of artificial drainage it is necessary to thoroughly apply the principles of asepis and antisepis, combined with buried sutures, fixation and alimentary or systemic drainage.
2. Where from any reason the production of serum cannot be controlled, its removal by drainage is a safer surgical measure than any attempt at sterilization in situ.
3. The time required for primary drainage is from twenty-four to sixty hours; to wait longer is to encourage trouble; to remove sooner than twenty-four hours is taking risks not warranted in the premises.
4. Capillary is to be preferred to tubular drainage in wounds other than those of the large cavities. For this purpose absorbable material should be selected, catgut being the best.
5. Where it is desirable to combine hemostasis and drainage in the same measure, the strips of iodoform gauze, as recommended by Mikulicz, fulfill a most useful purpose.
6. Where natural drainage can be utilized without producing unsightly cicatrices, artificial drainage should be dispensed with; when feasible combine the two.
7. Wounds involving the brain and cord had best be drained to avoid mechanical violence to the function of delicate structures by retained serum.
8. Necessity for artificial drainage will most often arise in wounds invading the large cavities, here inflexible tubular drains (glass) best meet the requirements, aided or not by materials acting by capillarity.
9. The method of secondary suture after primary wound secretion is over, advised by Kocher, seems to possess no advantage over drains that have to be removed, and certainly is not to be compared in convenience, comfort, etc., to the patient, to absorbable capillary drains.—*Alabama Med. and Surg. Age.*

Extirpation of the Kidney for Cancer.—In reporting a case of nephrectomy for renal cancer to the Berlin Medical Society, Dr. James Israel said some surgeons were inclined to reject this operation owing to the former great mortality (53 to 61 per cent). His own results have been much better, and among eleven extirpations for malignant tumors, only two cases died in consequence of the operation, a mortality of 18 per cent. As regards the final results two cases died after six and thirteen months respectively from recurrences. The remaining seven lived five and one-half, four and three-quarters, and two years, eleven, six and three months.—*Muench. Med. Wochenschrift.—Clinique.*

Diseases of Children.

A Case of Fracture of the Humerus in A Child One Day Old.—Gurlt has shown in a statistical table, comprising fourteen hundred cases (prepared by B. Gerber, *Gyoyazat*, No. 14, '93), that the above-mentioned fracture occurred but in five children who had not yet reached their first year. Of these five, there were three cases of fracture of the femur, one of the scapula, and one of the clavicle; none were recorded of the upper extremities.

Dr. Gerber's case is for that reason, a rare as well as an interesting one. On the 10th of December, '92, he was called to see a child, the complaint being made that it could not lift the left arm. A careful examination revealed a normally developed baby whose left arm, at about its upper third, was crooked, crepitation being easily demonstrated, showing the bone to be completely fractured. Reposition of the ends was produced by decided conuler extension. The entire arm is then encircled by a broad bandage, over which a splint made of heavy paper was properly adjusted, allowing the position of the arm to be at right angles, and then bandaged to the body after careful protection with cotton. The bandage was removed every seven days. After the removal of the second bandage there was sufficient callus thrown out, making the union at that early date secure. With the exception of the first few days, when a slight œdema of the fingers and hand was present, and which was removed by a gentle massage, the fracture healed thoroughly in three weeks, with no untoward symptoms—*Der Kinder Arzt, Med. and Surg. Reporter.*

Hiccough and Hereditary Syphilis.—According to the Carini (*Internation. klin. Rundschau; Union medicale*) hiccough in the new-born is to be regarded as a symptom of hereditary syphilis. It is of rather common occurrence; and is one of the earliest signs of the disease, coming on during the first few hours or days after birth, sometimes before the coryza. It lasts two or three weeks. The author's views are supported by numerous cases and by the effect of anti-syphilitic treatment on the hiccough.—*Clinique.*

Diseases of Women.

The Etiology of Vaginal Fistulæ.—Carl-Hohenbalken *Wiener med. Presse*, 1893, No. 8.) calls attention to the fact that a considerable number of cases of vaginal fistula are due to the presence of foreign bodies, especially improper pessaries, such as the Zwank variety. He reports two cases, in one of which such an instrument remained in the vagina for sixteen years; when it finally dropped out (the patient being then eighty years old), a vesico-vaginal fistula admitting two fingers was found in the upper part of

the vagina. An operation was deemed inadvisable, on account of the advanced age. In the case of the second patient, aged sixty-five, who came to the clinic on account of hemorrhage, a glass stopper was found in the vagina, which had been introduced fifteen years ago by a physician (!) on account of prolapsus; when this was removed a large recto-vaginal fistula, two inches long and an inch wide was exposed.

The writer deduces the lesson that not only should the physician be careful what sort of a pessary he uses, but he should be sure that the patient is not allowed to pass from under his observation without due caution as to the necessity of having the instrument removed.—*American Jour. of the Med. Science.*

Obstetric Paralysis.—The pathology and ætiology of this affection are clearly discussed by Dr. C. F. Carter (*Boston Med. and Surg. Jour.*, May 4, 1893). He tabulates Lovett's and Burr's reported cases and sixteen of his own, making statistics of thirty-two cases. He concludes that the upper-arm type of obstetric paralysis is due to a stretching of the upper trunk of the brachial plexus (formed from the fifth and sixth cervical nerves) during the process of delivery. This is brought about by traction on the head or pressure on the breech when the shoulder is retarded, or by traction on the shoulder when the head is retarded—not by pressure of the forceps, as often assumed. The prognosis, as a rule, is good, though recovery may be delayed for months or years. Permanent disability is rare.

The muscles paralyzed are the deltoid, supraspinatus, infraspinatus, teres minor, biceps, and brachialis anticus, with the supinators. In some of the severe cases some of the extensors of the wrist and fingers may be involved. The affected arm is held by the side in a position of internal rotation, the elbow pointing outward. The fingers are usually semiflexed. The paralysis is rarely noticed before the second or third day. After a few days the reaction of degeneration is well marked in the affected muscles, and, if one were able to test satisfactorily in such young subjects, diminution of sensation would probably be found on the outer aspect of the shoulder and upper arm and on the radial side of the forearm.

The treatment consists in the use of passive movements, massage, and electricity (galvanism two or three times weekly through the brachial plexus and affected muscles).—*N. Y. Med. Journal.*

Vaginal Hysterectomy.—Boldt (Amer. Journal Obst. and Dis. of Women and Children, Vol. xxvi., Nov. 4, 1892), after describing technique of the operation, calls attention in particular to and condemns the use of silk ligatures. He prefers catgut, and declares it holds sufficiently long to avoid rush of hæmorrhage, and that in trying catgut of large size only one twist is required in the first knot. Boldt recognizes the valuable galvano-cautery treatment by Byener, and the high amputation favored by Boker, and the difficulty of convincing those who differ so radically from them. He quotes 474 vaginal hysterectomies from five German clinics with a mortality of 8.4 direct mortality; also that of Zwiefel of Leipzig of 775.2 per cent mortality, and that of Byford with five per cent in twenty cases, and his own forty-four cases with 6.81 per cent. direct mortality.

In limiting the operation from a clinical standpoint, he raises the following question:

1. Does a movable uterus always indicate operation?
2. Is hysterectomy contra indicated because the parametria or the folds of peritonæum posteriorly are thickened?
3. Does a fixed or adherent uterus contraindicate total extirpation?
4. Is total extirpation of the uterus contraindicated when the disease is apparently limited only to the cervix?

1. In answer to the first question, he says cases are usually operable if the uterus is movable and the broad and utero-rectal ligiments not infiltrated. Involution of bladder and rectum is a contraindication.
2. Para or perimetritis, caused by traumatism or incident with puerperium, causing more or less fixation of uterus, would not render the case inoperable.
3. A fixed uterus invaded by cancer does not contraindicate total extirpation unless the disease has gone beyond the limits for operation, as the fixation may be due to former inflammatory adhesions.
4. If it can be shown that the disease is limited only to portio vaginalis or lower part of cervix, then total extirpation is contraindicated.—*Brook Med. Journal.*

Obstetrics.

Treatment of Puerperal Convulsions.—In an article on this subject, *Va. Med. Monthly*, Dr. John S. Hughson says:

From a large experience with both chloral hydrate and potassium bromide, I now discard them entirely from the treatment of puerperal convulsions. There are some few cases in which venesection may be beneficial, but from its frequent failure to cure the disease we cannot depend upon it. Chloroform is an excellent adjunct to the treatment, but possesses no curative powers. Opium internally is often prescribed, but the stomach is seldom in a condition to absorb anything, and how often is it that your patient is beyond the stage of being able to swallow. Now, what will you do? What do you know of puerperal convulsions? It is a perturbed state of the nervous system caused by the condition of pregnancy by a foreign body being in the uterus, an organ that is more freely sympathized with through the nervous system than any other in the body. Take a case: There is pain in the head, impairment of the senses, especially the sight, as sparks before the eyes, dimness of vision great irritability, feelings of distress, difficulty of articulation, all of these being referable directly to the nervous system.

Now, what shall we do? To quiet this disturbed condition of the nervous system is evidently the indication. Opium is the remedy; but the patient is writhing in convulsions, she cannot swallow, the breathing is becoming stertorous, the coma is deepening, and life itself seems to be fast ebbing away. And it is just here, in these terrible cases, that the hypodermic injection of morphine in large doses shows its power and wonderful efficacy for restoring the nervous system to its normal state, and aiding nature to throw off its burden, and though weak and prostrate, to recover the strength necessary to carry on the functions of the body. Do not hestitate to administer large doses, and at once, whatever else may be needed, that is an absolute necessity; not less than one-half grain,

and in severe cases a whole grain is imperatively demanded, repeating the injection as may be required.

DIFFERENTIAL DIAGNOSIS OF A RUPTURED OVARIAN CYST FROM RUPTURE OF AN EXTRA-UTERINE SAC.—Dr. Rosenstein (*Centralbl. f. Gyn.*, 1892, No. 41) reports a case in which rupture of a carcinomatous papillary cyst of the ovary took place in a woman who was in the fifth month of pregnancy. As the patient had been quite well until the sudden onset of alarming symptoms the night before, it was thought probable that a rupture of an extra-uterine sac had occurred. Cœliotomy was done and the ovarian tumor was removed. The uterus was found to contain the products of gestation. Abortion took place several days afterward. The absence of acute anæmia and discharge of blood from the uterus the author thinks is sufficient in a similar case to exclude extra-uterine gestation.—*N. Y. Jour. of Gynecology and Obstetrics.*

THE EFFECT OF COFFEE ON THE LACTEAL SECRETION.—Dr. Alice McLean, writing in the *Med. and Surg. Reporter*, says that in an institution of which she has charge recently, in which there were some thirty or so nursing women, coffee was served twice a week. Regularly upon these days the nurses in charge reported a scarcity of breast-milk, and there was frequently a necessity for resorting to artificial feeding to eke out. The author suggests that in the lying-in period, and at the time of weaning, when the breasts secrete more milk than is wanted, and when the mother is abstaining from fluids, her thirst might be quenched with coffee with good results.—*Med. Record.*

PUBLISHER'S DEPARTMENT.

Case of Collapse Caused by Antipyrine.

BY DR. L. A. TURNBULL.

Was called to see Mr. D., a carpenter, aged fifty-two years. Patient said that had always enjoyed very good health, but that during the last year he had been more or less subject to muscular pains, and pains about the joints in damp weather; these, however, had never been severe enough to cause for him to stop work. Two days before calling me he had been caught in the rain while going to work, and had allowed his wet clothes to dry on his body. Upon arriving at home that evening he had had a chilly feeling, afterward a fever and pain in the right kneejoint. At the time of my visit the patient was suffering from an attack of acute articular rheumatism. The temperature was 102, and joints very painful. I put him on the usual treatment for such cases, and with an idea that antipyrine would reduce the temperature and besides relieve the pain to some extent, until the disease was gotten under control, I ordered ten grains of antipyrine every four hours. I was hastily summoned during the night, and found the patient pale, sweating profusely and somewhat drowsy. His wife stated that she had given two of the antipyrine capsules (four hours apart) and that her husband had become unconscious after each capsule, and sweated profusely. I of course discontinued the antipyrine. At my morning visit the fever was again 102°, and I ordered antipuralgos, ten grains every four hours; this had no deleterious action and controlled the fever nicely. A careful examination of the heart failed to reveal any lesion in this case. About two years ago I treated a prostitute, in the course of whose malady an antipyrotic was needed, she also collapsed twice after taking ten grains of antipyrine, although other antipyretics did not cause any bad symptoms.

Trional as a Hypnotic.

In an inaugural dissertation presented to the University of Berlin Dr. S. Hammerschlag communicates his investigations with trional. Six hundred and fourteen grammes of trional were administered to sixty patients. The single doses varied from 1 to 3 grammes, the sum total of single doses being 395. The remedy was administered dissolved in warm milk about half an hour before bedtime. In cases where it proved effective a deep, dreamless sleep soon ensued from which the patients wakened as from normal sleep. Disagreeable aftereffects were never noted, with the exception of slight disturbances referable to the digestive tract. Even during prolonged use of the remedy nothing occurred to necessitate an interruption of the administration. In cases in which the drug had been given continuously for a long time the urine was examined and always found free from albumen.

The results of the author's observations which are given in the form of tables were as follows: 1. Melancholia, two cases, 16 single doses, ½ grammes always effective. 2. Mania, three cases, 17 single doses of 1 1-5 grammes, sleep produced in 6⅛ hours. 3. Hypochondriasis, one case, eight single doses of 1.5-2 grammes, effective. 4. Paranoia, ten cases, 114 single doses of 1 2-5 grammes, complete effect in ninety-one per cent of doses. 5. Hysterical dementia, one case, 20 single doses of ½ gramme, sleep obtained in 5-8 hours. 6. Epileptic dementia, four cases, 13 single doses of ½ gramme of which eighty-five per cent were completely effective. 7. Alcoholism, 30 cases, 91 single doses of ½ grammes of which 6 per cent proved perfectly satisfactory. 8. Morphine habit, three cases, 60 single doses of 1 2-5 grammes of which eighty-three per cent were active.

THERAPEUTICS IN THE SUMMER DISTURBANCES OF CHILDREN.—The careful observing physician can but be possessed of the facts which have been established by the delvers in the laboratory regarding the various bacteria being a primary and an aggravating cause of many of the summer diarrhœas of children. Many times when the intestinal irritations are pronounced; when the evacuations give evidence of fermentation; when the frequent unsatisfactory passages, accompanied by marked tenesmus and straining efforts on the part of the child, pointing strongly in the direction of dysentery; the administration of the one-hundredth to the fiftieth of a grain of corrosive sublimate to a tablespoonful of sweetened peppermint water, every two to four hours will be followed by almost magical results. Undoubtedly the remedy acts as a germicide, an antacid, as a stimulator of the biliary secretion and as such will serve us well. I have found in many conditions the following formula admirable:

Katharmon, one-half ounce.
Glycerine, one-half ounce (P. D. & Co.'s Pepsine.)
Cordial, three ounces.
Dose: A teaspoonful every two to four hours.

If there be any pain present and it be desirable to prevent excessive peristalsis, a few drops of paregoric added to each teaspoonful will be well. The profession is no doubt familiar with the component parts of katharmon, it containing acid salicylous from oil of wintergreen and boracic acid, but the most important of all, the dist. extract of witch-hazel. In this latter remedy witch-hazel, we have a more valuable astringent and antihemorrhagic agent than we generally realize. It is most soothing to any irritated surface. It is one of the best local remedies to relieve the tendency to bleeding which we have and we can readily understand that for this reason, if for no other, katharmon would often be indicated in dysentery or the old-fashioned bloody flux.

Joseph P. Ross, A. M., M. D., Professor Clinical Medicine and Diseases of the Chest, Rush Medical College, Chicago, Ill., says:

"For the past three years I have prescribed bromidia very frequently, and have never yet been disappointed in securing the results required. In cases when there is insomnia without pain, in the delirious stages of acute fevers, in delirium tremens, puerperal mania, in short, in all those cases requiring soporifics, I find bromidia invaluable. I consider bromidia an excellent combination.

Announcements.

New Orleans, June 20, 1893.

Editor, Western Medical Reporter.

Dear Sir: Desiring to present an article on the subject of "Complications of Tonsillotomy" at the next annual meeting of the Louisinna State Medical Society, I would request your readers to favor me with answers to the following questions:

1. Number of cases of Hypertrophy of faucial tonsils operated upon.

2. Complications occurring during these operations, stating nature of complications, and number of cases affected.

3. Method of operating in these cases in which these complications develop.

In publishing these cases, I shall omit the name of the physician who reported them, if desired.

I shall mail a reprint of the article, which I shall present at the meeting, to those physicians who send me a report of their cases, as above. Letters should be addressed to W. Scheppegrell, M. D., care of Eye, Ear, Nose and Throat Hospital, New Orleans, La.

Very respectfully,

W. Scheppegrell, M. D.

American Electro-Therapeutic Association.—The third annual meeting of the American Electro-Therapeutic Association will be held in Chicago, September 12, 13 and 14, at Appollo Hall, Central Music Hall Block.

Members of the Medical Profession interested in Electro-Therapeutics are cordially invited to attend.

Augustin H. Goelet, M. D., President.

Margaret A. Cleaves, M. D., Secretary.

Miscellaneous.

Antipyrinomania.—Under this name Dr. Cappelletti (*Revista sperimentale di freniatria e di medicina legale*, March 31; *Revu generale de clinique et de therapeutique*, May 17) writes of a mental affection caused by addiction to the use of antipyrine. An hysterical woman, twenty-three years old, had used the drug to excess for two years, to allay headache, taking every day as much as two drachms. She had become affected with loss of appetite, sleeplessness, tinnitus aurium, and muscular weakness. She entered a lunatic asylum of her own accord, to enable herself to abstain from antipyrine. The dose of the drug was reduced, but this produced such a state of prostration and such grave functional disturbances, even when the patient was unaware of the reduction, that potassium bromide and caffeine were resorted to. The patient was finally cured of these ill effects and of her craving for antipyrine. The author recommends the gradual reduction of the dose in such cases.—*N. Y. Med. Jour.*

The Founder of Journalism and Dispensary Practice.—In Richelieu's day there lived in Paris a doctor named Théophraste Renadot. This man was an intimate friend of the genealogist d'Hozier, who often allowed him to take copies of letters received from different cities in Europe. It occurred to Renaudot that what gave so much pleasure to himself might also interest his patients. Possibly he fancied physic would work better combined with light doses of literature. At any rate, tradition has it that Renaudot usually paved the way to a prescription with one of d'Hozier's letters. The system worked so well that the worthy doctor thought of putting the letters within the reach of others by having them printed. Richelieu granted the necessary license, and thus began the famous *Gazette de France*, for a long time the only French public journal. It is still in existence, and is perhaps, says Granville Murray, the only paper in the world that has never modified the color of its opinions, for it remains to-day, as before the great revolution of '93, entirely devoted to the Bourbons. Renaudot died "as poor as a painter," according to one of his enemies. Gilles de la Tourette has recently written a brochure of Renaudot's life, to help defray the expenses of a statue to be erected shortly in Paris in honor of the founder of journalism and dispensary practice.—*N. Y. Med. Record.*

The Supression of Information about Cholera in France.—Surgeon Fairfax Irwin, of the United States Marine Hospital Service, reported in the *Abstract of Sanitary Reports* for June 16 that the authorities of Marsailles had not only refused him the opportunity of inspecting the records, but suppressed everything relating to cholera, and that the newspapers were not permitted to publish the causes of deaths. The *Medical Week* for June 16th independently corroborates this report, stating that both the local and the central authorities seem once more to be endeavoring to conceal the truth, or at any rate to hide it under all sorts of designations. A rapidly fatal diarrhœal disease has appeared in a number of the maritime departments of France, but not a single systematic bacteriological examination has been

made. This course of concealment and perversion is in direct conflict with the agreement made at the recent sanitary conference at Dresden, and, though the agreement has not been yet ratified, it has been accepted by the various signatory powers, one which was France. Perhaps if our health authorities declared France infected with cholera, the local authorities would realize their duty.

THE SURGEON'S ENEMIES.—The surgeon's enemies are almost always sporeless bacilli, and though some of these show great resistance to the action of antiseptics, such as the staphylococcus pryogenes aureus, the common cause of suppuration, it has nevertheless been shown that carbolic acid destroys these organisms more rapidly than corrosive sublimate.—*Lister.*

OPERATING ACCIDENT.—A sad and unusual accident is reported to have occurred recently in the operating theater of one of the London hospitals. One of the surgeons was engaged in sewing up the wound after a laparotomy, and, while in the course of doing so, he seems to have given a flourish to the needle in his hand, which penetrated one of the eyes of his assistant. The latter continued for some moments to attend to his duties, but was afterward compelled, owing to the pain in his eye, to leave the side of the operating table and sit down on one of the benches in the theater. As soon as the operation had been completed the surgeon examined the injured eye of his assistant, and found the lens was lying outside the organ, the sclerotic extensively torn, and the vitreous protruding.—*N. Y. Med. Record.*

MID-OCEAN AIR.—In an article an air and contact Inspection, *The Clinique*, Dr. Frank J. Thornburg records the following:

Upon the fact of the absence of bacteria in the air of midocean I convinced myself in a recent transatlantic voyage. While still in the harbor of Antwerp, bacilli were present in the air, varying in number from three to five hundred per cubic meter, as determined by aspirating the air through large glass tubes. Sailing down the Schelda River the number decreased to two or three hundred, and in the North Sea almost no germs were present. Upon entering and sailing through the English Channel, the observations continued, revealed the presence of bacteria in the air varying from one to three hundred per cubic meter, although in the wider parts of the Channel the number detected on exposed gelatine and agar plates was much less. Beyond the Scilly Islands the bacteria gradually diminished and in the Atlantic Ocean from five to forty degrees west longitude no germs at all were present.

COLUMBIA COLLEGE GENERAL CATALOGUE—At a meeting of the trustees of Columbia College, held on the 6th of March, the publication of a new general catalogue of officers and alumni was authorized, and a committee, consisting of Prof. J. Howard Van Amringe, and Mr. John B. Pine, clerk of the board, was appointed to prepare the same. The new edition, which is to be issued in 1894, will be the eleventh since the foundation of the college, and will be also the most elaborate and comprehensive. The dead and living almuni of the college now number considerably more than eleven thousand. In previous catalogues all almuni have been divided into schools, and arranged by classes, with an alphabetical conspectus. Only the degrees of graduates were added to the names. It is the intention of the present committee, for the first time, to supplement the names of living almuni with their addresses and with such further information as may properly enter into a work of this description, including the professions of the men, their degrees, the college at which they were granted, their title, judicial, military, clerical or political, etc. While the committee is in possession of the present addresses of a great number of the almuni, the list of graduates whose whereabouts are unknown is still appallingly long. To locate these men will be a difficult and troublesome task, which can only be accomplished by patient and persistent effort on the part of the committee, entailing a great amount of clerical work, correspondence, etc., and by the cordial coöperation of the almuni themselves. It is this coöperation which is most earnestly desired by the committee, and they appeal to every alumnus of the college, no matter of which school, to assist them with whatever pertinent information may be in his possession. It will at least be possible for every graduate of Columbia who reads this to forward to the committee his own name, class, and present address, with such other facts regarding himself as he deems material. The list of the missing among the graduates in medicine is, notwithstanding the excellent catalogue of the College of Physicians and Surgeons, published in 1891, especially lengthy. Physicians holding diplomas from the medical school are most urgently requested to respond. Alumni who may be so far interested in the progress of this important undertaking as to go beyond the data concerning themselves will confer a special obligation upon the committee if they will inform them (1) of any living graduate known to be now residing or practicing bis profession outside of the United States, with his address and class, when known; (2) of the death of any graduate, occurring within the past five or six years, date and place, when known; (3) of recent changes of address among alumni; (4) of anything else suggested by the foregoing description of the committee's intentions. The work, when completed, will be circulated generally among the alumni, and it is hoped that it will exert an important and sensible influence in bringing them into closer union, besides serving many useful purposes that need not be here detailed. All correspondence may be addressed to the Committee on the General Catalogue, Columbia College, New York City. —*N. Y. Med. Journal.*

AN APOLOGY FOR TOBACCO.—The proscribed cigarette is not without its defenders, Its character has qeen vindicated by Dr. Walter S. Haines, Professor of Toxicology in Rush Medical College, who called in to curse, has been obliged by his scientific conscience to bless, or at any rate absolve, the cigarette. He said he had made a chemical analysis of eight or ten different brands of cigarettes, and had discovered no deleterious ingredient and no substance more detrimental to health than is contained in cigars. Positive evidence of a much stronger kind is given by Dr. A. A. Smith, Professor of Practice of Medicine in the Bellevue Hospital Medical College, New York. In a recent clinical lecture, that physician, while admitting the possible evil effects of the abuse of tobacco, said it was not always wise to make a patient with any chronic disease, particularly of the heart, give up

smoking. He met with many cases in private practice in which smokers who had heart disease suffered from palpitation, dyspnœa, and præcordial distress on the slightest exertion when they abstained from tobacco, whilst, on the other hand, if they continued to smoke, compensation was well maintained, and no particular ill-effects were caused by the valvular lesion. Among other cases cited by Professor Smith in support of his thesis is that of a yound medical man who was told ten years ago that he had grave vavular lesions, and that he not many years to live. The young man, taking a philosophic view of the situation, thought he had better smoke as much as possible while he had the chance. He has been doing so ever since, and the outlook is now better than it was ten years ago. Dr. Smith also refers to two Russian ladies who are in the habit of smoking cigarettes. Both have organic heart disease, which gives them no trouble unless they forswear tobacco for a time, when symptoms of loss of compensation soon show themselves. Dr. Smith deprecates the inference that the use of tobacco is justifiable in all cases of heart disease, or even in the majority of them. He holds only that it is not contraindicated in all cases. His facts, however, may fairly be taken as showing that in smokers, at any rate, tobacco is positively indicated in certain conditions, and lovers of the cigarette will be glad to have the support of so powerful a champion.—*London Lancet.*

"Red Chromidrosis."—This is the title of an article contributed by Dr. M. B. Hartzell to the July number of the *University Medical Magazine.* It is much to the author's credit that he puts a question mark after the title, although only on pathological grounds—namely, that the disease, of which he gives notes of three cases, is not a true chromidrosis, for the sudoriparous glands are not affected, or, at most, play only a secondary part in the production of its phenomena.

"In none of these cases," he continues, "was the sweat colored at the time of its excretion, but it seemed to act as a solvent for the coloring matter present in the small excresences upon the axillary and perineal hairs.

"A microscopical examination of the nodules with a magnification of two hundred diameters shows that the fungus began to grow upon the surface of the hair, but with the growth of the parasite the hair itself was penetrated, being split up into numerous small fibers, and, in the case of the perineal hairs, fracture of the hair shaft occurred with the production of brushlike ends in which the small brown mass was lodged. In the larger nodules a magnification of some eight hundred diameters showed numerous parallel striæ running at right angles to the shaft of the hair, while in the fine colorless hairs upon which the fungus was just beginning to grow a fine dotted appearance was seen.

"Upon subjecting the hair to the action of liquor potassæ and afterward crushing the nodules thoroughly upon a slide, staining with safranin and mounting in glycerin, a higher power showed that the mass was composed of numerous micrococci which grew between the fibers of the hair and around the shaft, and were held together by a yellowish or orange colored amorphous substance. A few attempts at culture upon sterilized potato at the ordinary house temperature were made, but without success.

"Dr. Kneass, who kindly undertook to make some culture experiments for me in the pathological laboratory of the University of Pennsylvania, succeeded in cultivating the fungus upon sugar at a temperature of 37° C. The fungus began to grow within a few hours after implantation, but instead of the brown or orange color, as seen upon the hair, it was sulphur yellow. Examination of pure cultures showed the cocci frequently arranged in pairs and tetrads, resembling in this respect *Micrococcus tetragonus.* As the same fungus was obtained from the hair of different patients, it is fair to presume that this microcuccus is the one concerned in the production of the nodules upon the hairs. Upon coagulated albumen the fungus grew much more slowly.

"Although this malady has been known for some time its true nature has only been determined within a comparatively recent period. Hoffman and Pick, in Germany, and Babes, in France, first pointed out that the red color was due to a fungus growing upon the hair, which the last named author succeeded in cultivating upon coagulated albumin. The pigment, according to Babes, who examined it spectroscopically, resembles that produced by the *Micrococcus prodigiosus,* the fungus concerned in the production of the so-called 'bleeding host.' The identity of the two organisms, however, has not yet been proved. By scraping the epidermis in the axillary and perineal regions, organisms similar to these upon the hair have been found, but not all of those were pigmented—many of them were colorless. Balzer and Barthelemy, who have also studied the matter carefully, are of the opinion that it is much more frequent than is commonly supposed, since they were able to collect a considerable number of cases by examining individuals at random. The pigment is not always red, but may be of a yellow hue, and these authors found instances in which the parasite was present upon the axillary hairs without any pigment accompanying it. In most cases the sweat is usually abundant, but it is not yet known whether qualitative changes in this excretion are necessary for the production of the disease.

"It would seem that blondes are more frequently affected than brunettes, and that weakness and debility are predisposing conditions, although the robust are not exempt.

"As has already been mentioned, the sweat is colorless upon its excretion, and for this reason the name chromidrosis should be abandoned; the malady is, in fact, one of the hairs, and not of the sweat gland.

"As the disease is not attended with any annoying symptoms, treatment is rarely sought unless the staining of the underwear is considerable. In the writer's case alcholic solutions of bichloride of mercury, two to three grains to the ounce, were employed as lotions with some degree of success; but much more speedy results would probably be obtained by first shaving the affected regions, as in this manner a large part of the fungus would be removed at once."

At a New Jersey Sanitarium.—Pilkins—"I don't see why you charge me $6 a day when you charge others only $4?"

Hotel Keeper—"Our medical adviser tells me your respiration is twenty-five per cent above the normal. We don't give air like ours away."—*Puck.*

Items.

Pilocarpine Turns the Hair Black.—At a meeting of the Medical Society of Washington, D. C., May 10, 1893 (reported in the *National Med. Review*), Dr. D. W. Prentiss showed specimens of hair which had turned black during the administration of pilocarpine. In one case the eyebrows turned dark after its administration for two years. Dr. W. W. Johnston also referred to a patient whose hair had turned dark during a prolonged administration of the drug. —*Med. World.*

Do the Sick Ever Sneeze?—"Do those who are seriously ill ever sneeze?" This is a point alluded to by Mr. Jonathan Hutchinson in the January number of his *Archives*. He does not recollect himself to have seen any but fairly healthy persons sneeze. He puts the question with especial reference to the widely spread popular superstition that sneezing is a sign of health and good luck. It is possible, he thinks, that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, in his "Primitive Culture," gives interesting facts as to the prevalence of this creed as to certain customs associated with it and traces it in part to doctrines of animism, but Mr. Hutchinson thinks the suggestion he has given may also have some value.—*Sheffield Med. Journal.*

Wit and Humor.

"What did de doctah say ailed yer mostly, Bill?" "He 'lowed dat I had a conflagration of diseases. Fust, de salvation glan's don't insist my indigestion; dat makes a torpedo liver, cose I'm liable to go off any minute."

She.—"Isn't Dr. Anderson very absent-minded?"
He.—"Yes. That's why he never married. He went to kiss his sweetheart's hand once, but vaccinated her instead."

A Natural Supposition.—Mr. Tulkinghorn—"There is a very fine picture of our minister in today's paper."
Mrs. Tulkinghorn—"Indeed! What has he been cured of?"

Timid Lady—"Oh, doctor, do you think cholera will get a foothold in America?"
Doctor—"Certainly not, madam, that isn't the kind of hold that cholera gets in any country."

Doctor—"I think I will prescribe wine for you, now that you are convalescent. If I were you I would try the virtues of a good hock."
Patient (weakly)—"That's what I did to settle your last month's bill, doctor."—*Town Topics.*

Pryer—"What medical college is your physician a a graduate from?"
Guyer—"Medical college! Huh! He's no medi-college fledgeling. He's a graduate of the jury which listened to the expert testimony in a great poison case."—*Puck.*

"But, doctor, you said last week that the patient would certainly die, and now he is perfectly well."
"Madam, the confirmation of my prognosis is only a question of time."—*Fliegende Blatter.*

An exchange publishes the following bill-head of a doctor in Kansas: "A prompt settlement of this bill is requested. If bills are paid monthly a discount of ten per cent is allowed. Bills not paid monthly will be passed to my attorney for collection. If you pay your doctor promptly, he will attend you promptly, night or day, rain or shine; while your slow neighbor suffers and waits, as he made the doctor wait, and while he is waiting the angels gather him in."

As Others See Us.

Mr. Gill and I were talking
(He's a chemist, I'm a hatter);
Came a sobbing urchin walking
To the counter, "What's the matter?"
"Mother's ill; the doctor ordered
This prescription. please, sir, make it."
Mr. Gill mixed up a bottle,
Wrote upon it how to shake it,
Tied it carefully in paper
(For our chemist neat and nice is),
Gave it to the little urchin:
"One-and-three, my child, the price is."
Gone the boy—upon the counter
There was only threepence lying;
To the doorway rushed the chemist,
Hands outstretched, and coat-tails fling.
Mr. Gill is fat and heavy;
He came back all red and blowing:
"Little rascal, he has vanished,
Where he's gone to there's no knowing!
After all, I have the threepence
(In the till he went to drop it)—
Though I haven't got the *shilling.*
I have still got *twopence profit!*

—*New Zealand Journal.*

Pamphlets Received.

A unique Case of Traumatic Neurosis. A paper read before the Central Ohio Medical Society, at Columbus, Ohio, November 3, 1892. By R. Harvey Reed, M. D. Reprinted from the International Medical Magazine for May, 1893.

Colles' Fracture. Illustrated by photographs of cases and of splints used in treatment; also a new mechanical combination splint for the treatment of other fractures of the upper extremity, illustrated by photographs. By. E. H. Woolsey, M. D. Reprinted from transactions of the Medical Society of the State of California.

Deformities of the Nose Septum and their influence in Diseases of the Ear and Throat. By Wm. Scheppegrell, A. M., M. D. Reprinted from the New Orleans Medical and Surgical Journal.

Remarks on the Presentation of Diplomas to the Graduating Class of Barnes Medical College. By C. H. Hughes, M. D. President of the Faculty and Professor of Neurology, Psychiatry and Electrotherapy. Reprinted from the Alienist and Neurologist.

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ORIGINAL ARTICLES.

An Ovarian Tumor Weighing 111 Pounds Removed from a Child of Fifteen, Whose Weight was Sixty-eight Pounds.

BY W. W. KEEN, M. D.

Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College.

Miss B., of Benezette, Pa., was first seen by me at Driftwood, Pa., February 26, 1892, at the request of Dr. V. K. Corbett, of Caledonia. She was then fourteen years of age and had never menstruated. About eighteen months before I saw her, her abdomen began to enlarge. Six months afterward Dr. Corbett was consulted for an attack of considerable pain in the left side of the abdomen. He found that she was only voiding eight ounces of urine in the twenty-four hours, but under proper treatment this soon reached a quart in amount, and has remained so ever since. He never discovered any albumin in the urine. In October, 1891, she had been tapped by a gynecologist, who is said to have diagnosticated a solid and probably malignant tumor, connected most likely with the liver, omentum, and ovary, and who deemed its removal not feasible.

I found the abdomen enormously distended with fluid and advised very strongly that a small incision should be made in the abdominal wall, so that I could determine the relations of the growth with accuracy. Her father, however, was not present, and had made it a condition that nothing beyond tapping should be done. I tapped her immediately, and removed considerably over three gallons of amber colored fluid. When this was evacuated I discovered a lobulated tumor on the right side of the abdomen, under the liver and apparently attached to it. It was evidently cystic in part, there being at least two cysts perceptible. Each of these I tapped, obtaining from the upper one a light fluid and from the lower one a much darker fluid. On account of her age no vaginal examamination was made. The fluids pointed strongly toward an ovarian cystoma. I again advised an exploratory incision.

April 29, 1893. The patient was finally brought to the Jefferson College Hospital. She has been tapped twice since February, 1892, the last time in February, 1893, when six and a half gallons were drawn off. She is now enormously swollen. The measurements are as follows: From the ensiform to the umbilicus, 16½ inches; from the ensiform to the pubes, 29½ inches (this measurement in myself reaches from the ensiform to the middle of the calf of my leg); circumference, 49 inches. The veins over the abdomen are very large. Nothing can be made out in the interior in consequence of the enormous abdominal distention. Examination of the urine shows no albumin and a very slight trace of sugar (?)

Operation. April 30, 1893. A small incision was made in the median line above the umbilicus, as the greater mass of the tumor lay there. A large trocar was thrust in and evacuated a very large quantity of characteristic opalescent ovarian fluid. The escape of this fluid revealed through the abdominal wall large masses lying especially under the liver in the right iliac fossa. After this evacuation I enlarged the incision until it measured eventually about eight inches in length. I introduced my hand and found an enormous ovarian cyst, reaching up to the diaphragm and pushing everything out of its way. There were a number of moderate adhesions, chiefly to the belly wall and the omentum. The viscera were fortunately entirely free. The pedicle was only 2½ inches broad. The tumor arose in the right ovary, the left ovary being healthy but small.

The weight of the solid mass removed was twenty-seven pounds, and by actual weighing the fluid removed weighed eighty-four pounds, making a total of 111 pounds. The child herself weighed but sixty-eight pounds.

After the removal of the tumor I never saw so curious a looking abdominal cavity. It looked almost like that of an eviscerated cadaver in the dissecting room. The tumor had so pushed the liver to the right and backward, and the stomach to the left, that nearly the whole of the diaphragm was exposed, and flapped up and down with the pulsations of the heart. Down the middle of the cavity the bodies of the vertebra were entirely exposed, showing the aorta and vena cava to their bifurcations, the intestines being a very minor consideration and pushed to each side in the hollow of the ribs and the lumbar region. When the abdominal wall was sutured the abdomen was excessively scaphoid, the anterior abdominal wall lying directly on the aorta and vertebræ. The puckering of the skin, although moderately marked, was much less than I had expected.

When the operation was completed a glass drainage-tube was inserted, and she was put to bed in very fair condition, in view of the gravity of the operation. The tumor was a multilocular cyst.

May 18, 1893. The child has made an uninterrupted recovery. The drainage-tube was removed on the fifth day, when the discharge had become almost nothing, but three days later a slight rise of temperature took place, and the discharge recommenced. A small rubber drainage-tube was therefore reinserted for a few days. She sat up at the end of two weeks, and will go home as soon as the slight discharge from the drainage opening ceases.

REMARKS. I have not had time to search through the literature of ovariotomy, but so far as my memory serves I have never known a larger tumor removed from a child. It weighed just one and a half times as much as the patient. Her recovery has been most satisfactory in spite of a very poor and capricious appetite. The chief lesson the case teaches is the value of an exploratory incision in every case of doubt. Had this been done, instead of a mere tapping, in October, 1891, when the tumor was much smaller, the prognosis would have been much more favorable, and she would have been spared a year and a half of needless suffering. What seemed to be a most formidable operation really proved to be almost a simple one, the adhesions and the pedicle being most favorable for the speedy recovery which has ensued.

The Question of Substitution in Prescriptions.

G. Frank Lydston, M. D.

One of the most vital questions which everyday practice brings to the attention of the physician is that of substitution by the druggist of perparations that are "just as good" for the special preparations ordered by the physician. Substitution is so common as to be accepted by the profession as an almost necessary evil, or at least an evil that cannot be remedied.

The relation of the patient to his doctor is mainly a matter of confidence; there are other doctors quite as good, but he wants his old and tried friend, or if the doctor be not an old and tried friend the patient demands one who is generally known to be reliable. The same feeling is entertained by the doctor toward the preparations of certain old and tried or at least indubitably reliable firms. It is the height of presumption for the druggist to say, "I have none of X's quinine but I have K's, which is just as good," and then put up K's where X's was specified. The druggist might as well say, "I have no iodoform, but iodol is just as good," and proceed to dispense the iodol where iodoform is ordered. As an artisan works best with the tools with which he is familiar so the doctor gets the best results with the preparations in which he has the most confidence, born of experience. Even where the preparations of reliable firms are contrasted there may be some choice. Here is an example which may appeal to some: The powdered oleate of zinc prepared by Merck is a very crude preparation while that of Parke, Davis & Company is a really elegant preparation. They may be others as good, but I have no time or taste for experiments which benefit no one but some manufacturer. When I fail to specify P. D. & Co.—and often when I do specify—Merck's is dispensed as "just as good," with very unsatisfactory results. When I specify Schieffelin or Warner's pills I expect to have them dispensed. The question as to substitution should be referred to me for decision. When I specify Renz & Henry's "Three Chlorides" I want that particular preparation and no other. I want no imitation or bastard preparation from an irresponsible imitator, and have no time to determine the merits of "just as good" preparations. There may be other preparations of ether, ergot, etc,, as good or better than Squibb's, but we know that Squibb's preparations are reliable and we usually specify them.

There is something to be said on the other hand, regarding the ready-made doctor who likes his therapeutics mapped out for him by some quasi quack drug company. Such doctors are a nuisance to the druggist and hardly a credit to the profession. Does the stomach ache? Dr. Ready Made gives stomachine. Are the kidneys deranged? He gives kidneyol, and so on. As another example of the difference between the preparations of reliable firms, I will mention eucalyptus. Sander's is a good preparation, but Tyndale's is a better one, in my opinion, and altogether to be preferred. In using eucalyptus as a urinary antiseptic I have found it of the greatest importance to avoid gastric irritation. Ordinary preparations are objectionable on this ground, and where the pharmacist takes it upon himself to substitute other preparations than the one ordered, serious results may follow. Another illustration is found in the balsamic preparations used so extensively in genito-urinary practice. Nowhere is dishonesty more often encountered than in these preparations. I have found it absolutely necessary to specify either the Planten or P. D. & Co. capsules. By so doing I have been able to judge of the efficacy of the balsams. There is no doubt that a multiplicity of special preparations give the druggist much annoyance; but after all, it is the good of the patient that the physician should consider, and not the convenience of the pharmacist. It is well to bear in mind, however, that many preparations foisted upon the profession by manufacturing drug houses, are twice as expensive and not half so reliable as those which can be made up from a scientific prescription by any first-class druggist. I would warn the physician at this point against firms that are using the profession as a blind for pushing proprietary medicines. The physician who prescribes Scott's Emulsion—which is now advertised in the daily press as a cure-all—might with equal propriety order Hood's Sarsaparilla or Warner's Safe Cure. One of the most contemptible tricks ever perpetrated upon the profession was done through the medium of the Midy capsule of sandalwood oil. After popularizing through the medium of the profession, a preparation bearing the stamp of the originator in prominent letters on each capsule, the unprincipled manufacturer is now advertising it—or permitting its advertisement—as a three days' cure for gonorrhœa.

In conclusion I will state it as my belief that specification of preparations is often a necessity, and that no substitution should be tolerated. Preparations emanating from firms who are clandestinely or openly catering to the general public, should be tabooed. Preparations which are a palpable imitation of tested and reliable ones, the reputation of which has already been earned should be avoided, and the firms putting them upon the market regarded with suspicion.

Fracture of Humerus in an Infant One Day Old.

By A. J. C. Saunier, M. D., Chicago, Ill.

The report by Dr. B. Gerber in a recent journal that fracture of the humerus in children under one year of age, occurred but once in fourteen hundred cases, leads me to report a case which occurred in my practice about nine years ago.

I was called to take care of a mother and child the day after her accouchment by another physician, and found the child to have a sustained a fracture of the left humerus in the upper third and also a depression of the right parietal bone in its central portion, the concavity being about as large as a silver half dollar. The humerus was completely fractured. It was placed in a pasteboard splint, which covered the shoulder. Union took place in about two weeks, considerable callus being thrown out. The arm eventually became as strong and straight as the uninjured one. Nothing was done for the depressed portion of the skull, except to try to restore it to shape by pressure exerted on the edges of the bone by the fingers. I could not see that the depression was lessened any thereby. The condition did not seem to trouble the child, which was under my observation for about a year, and the concavity grew somewhat less as the head increased in size. It did not seem to effect the intelligence of the child.

Whether the depression was outgrown or not I do know. No blame could be attached to the physician for his rough handling of the infant, for the father became drunk during the time of his wife's labor and stood at the window outside the house with a loaded shotgun encouraging the doctor to strenuous efforts to shorten the time of labor by threatening to shoot him if the child was not born in a given length of time.

THE WEIGHT OF THE TWO SIDES OF THE BRAIN.—Prof. Braune, of Leipzic, has recently published the results of weighing the halves of 100 human brains. These were divided in the median line, and the cerebellum, with the medulla and pons, were cut off and bisected. The weight of the two sides of the whole encephalon were compared, as well as that of the cerebral hemispheres, and the halves of the cerebellum with the medulla and pons. It has generally been taught that the left half of the brain is heavier than the right, and that this is a physical cause of right handedness. The results of Prof. Braune's investigations do not seem to bear this out. He found the left side of the entire brain heavier in 52 cases, and the right in 47 cases, the two sides being equal in one case. And he also found that if the excess of weights of the two sides be added up, the right side showed a preponderance, the difference between the two sides being in most cases so slight as not to deserve any consideration. In five cases in which the right side considerably outweighed the left, the bodies were examined for signs of left handedness, but none were found. The left cerebral hemisphere was the heavier in 54, the right in 37 cases; while the left side of the cerebellum was the heavier in 54 and the right in 33 cases. Thus he found that the cerebral hemisphere of one side is the larger about as often as the cerebellum of the other, but the larger halves are on the same side about twice as often as on different sides.—*Boston Medical and Surgical Journal.*

Dr. A. J. C. Saunier.

Quite a sensation has recently been made in Boston by the successful application of wool-fat or agnine to the skin for the removal of wrinkles. When applied with rubbing, it passes directly through the skin and acts as a nutrient to the fatty tissues beneath. An ancient dame has succeeded in removing nearly all the crows-feet from around her temple, and the remedy is fast becoming very popular.

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JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D.,
HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Biographical Sketch of Dr. A. J. C. Saunier.

Dr. A. J. C. Saunier was born in Oakland county, Michigan, in 1857, and removed to Newark, N. J., six years afterward. Being compelled by financial circumstances to earn his own support, he began business life as a newsboy, at the age of ten, and until seventeen years old was enabled to keep up expenses thereby and at the same time attend the excellent public schools at Newark. Upon leaving the high school he entered the drug business, and at the same time commenced the study of medicine under the guidance of Dr. H. M. Weeks, now of Trenton, N. J. In 1877, he came to Illinois and took up the role of pedagogue in the "deestrick skule." He entered medical college at the University of Michigan in 1878, and alternately taught school and attended college until his graduation, in 1881.

He entered practice at Nunda, Ill., but soon moved to Libertyville, where he engaged in general practice until 1877, when he came to Chicago, with the intention of devoting his time to the study and practice of gynæcology.

He lectured for seven years at the College of Physicians and Surgeons, first on histology and then on gynæcology, filling Prof. Reeves Jackson's chair as acting Professor of Gynæcology during the latter's trip about the world in 1890-91. He was also Secretary and attending gynæcologist to the West Side Free Dispensary, for several years. Dr. Saunier is a member of the Illinois Medical Society, the American Medical Association and the Pan-American Medical Congress. His literary degree of Master of Arts was received at the Illinois Wesleyan University, and he holds the professorship of gynæcology at the Clinical College of Medicine and Specialty Hospital, and of special physiology at the Chicago Ophthalmic College.

Dr. William A. Hammond and the Humor of Him.

The humor of the versatile Dr. Hammond is not the least of his attention commading qualities though it developed late in life and has just reached its climax. Inspired by this sense of humor but humorously concealing his inspiration under a scientific cloud the amiable doctor prepared a large sounding, heart inspiring article on cerebrine, testine, and other ines and forwarded it to a most excellent medical journal. The editor of this publication, not appreciating the humor of the thing, treated it seriously, and published it. Numerous other journals reproduced the article, more or less completely and one reputable firm began making cerebrine, modifying the humorous doctor's formula as it saw proper. Then the humorous end appeared. The virile and inspiring contribution proved to be an advertisement for a manufacturing concern, the offices and stock of which are held by Dr. Hammond and his relatives. The delicate sense of humor of the Doctor is manifested in his sportive and successful effort to secure advertising in the best mediums without contributing to the expenses of the publications as other advertisers are required to do. Surely the Doctor's wealth is so great that the cost of advertising can be of little moment to him. We are constrained to believe that he is actuated, not by a desire to save money or to "work" publishers for space, but a humorous disinclination to be placed on the same plane with other makers and venders of ines. Gradually but surely the pleasant, humorous methods of Dr. Hammand are preparing the public to bear quietly and without quanantine an epidemic of ines which threatens to continue till the climax, Hammondine, is reached.

A Warning to the Readers of Our Journals.

All publishers of medical journals, no doubt, have had the experience of submitting to the depredations of imposters, who call upon physicians to collect, under an assumed name, claiming to have authority to make collections.

The latest that has been reported to us is a certain Ed. E. Evans, representing himself to be an agent of the law and literary exchange of Boston, E. L. Wanamaker, President.

This man called upon physicians, soliciting subscriptions for our journals, collected money for them, and made no returns to the publisher.

We cannot find that the Law and Literary Exchange, who claim an address in Boston and Chicago, have an address in either city, and inform our readers that they should not pay subscriptions to unknown collectors.

Freckles can be removed, according to Hager, by the application every other day, of an ointment composed of white precipitate and subnitrate of hismutb, each 3i; glycerine ointment 3ss.

A curious accident is described in the *Hosp. Gazette.* An eyelash happened to be carried into the eye by an accident, took root in the iris, and grew in coils in the anterior chamber, until it had to be removed.

ABSTRACTS.

Medicine.

SHOULD WE TREAT FEVER?—This question is discussed by Dr. S. T. Armstrong (*Med. News*) who terminates his study of the question by saying that in this review of the question whether it is desirable to relieve pyrexia by the administration of antipyretics, the following points have been held in view:

1. That fever is the expression of some disturbance of the thermal centers.

2. That while this disturbance may be traumatic, it is usually the result of the existence in the organism of certain autogenetic or heterogenetic (infectious) products that have the same affinity for the thermal centers that certain vegetable alkaloids have for certain cerebal centers.

3. That fever does not exercise any beneficial effect in limiting an infectious process; this is a fact that has been known clinically for years by the occurrence of cases of infectious disease that pursued their usual course without any rise of temperature.

4. That it is the general experience of clinicians that the relief of fever exercises a beneficial influence on the general condition of the patient, though the apyrexia does not indicate that the cause of the pyrexia has been removed.

5. That in many febrile conditions the causative principle has produced a thermetaxic paresis that is at once relieved by some suitable antipyretic.

6. That in continuing the employment of antipyretics we are not losing sight of the possibility of obtaining, either synthetically or derivatively, compounds that will, when administered in the specific diseases, have the same inhibiting influence on the further development of the microörganisms of those diseases that certain alexines, toxalbumins or toxines have. The action of such compounds should be as specific in each infectious disease as is the action of quinine in paludal fevers.—*Weekly Review.*

PULMONARY EMBOLI FOLLOWING MERCURIAL INJECTIONS.—Insterstitial injections of mercury, so largely used at present in the treatment of syphilis, are sometimes dangerous. Dr. Blaschko has reported two cases in which the injections of mercury were followed by pulmonary symptoms. In the first case, the patient complained of thoracic pain, coughed, and had accesses of oppression. On the day after the injection, the respiration became difficult, and the patient coughed bloody sputa. The second patient also complained of pain in the side, coughed, expectorated bloody sputa, and had a little fever. The symptoms in both cases disappeared in about three days. In a third instance, the patient had violent attacks of cough after the injection. These symptoms are explained by the author as being due to emboli caused by the paraffin employed as a vehicle for the mercurial preparations, which are insoluble, and are only suspended in the liquid. The writer believes that the mercurial injections give the best results in the treatment of syphilis, but that they must be administered by themselves, as in this manner they produce no untoward effects. The injections should not be so frequent in individuals affected with pulmonary troubles, especially phthisis.—*Therapeutic Gazette.*

ANGIAPHOBIA.—This is the name given by Huchard

to a condition often seen in patients who are fearful lest they have heart disease. He cites the case of a hypochondriac who consulted him for angina. Examination demonstrated only a pseudo-angina—that is a cardialgia. Douches were ordered; the patient was not convinced, however, that he did not have heart disease. Two years afterward he committed suicide by shooting himself through the heart. Huchard gives the following three laws for differentiating true and pseudo angina:

1. Angina produced by effort is a true angina.
2. Angina produced spontaneously is a pseudo-angina.
3. If angina shows itself after effort and disappears, then reappears spontaneously, as it were, at night, the first law still holds, and we have to deal with a true angina.—*Journal of Nervous and Mental Diseases.*

Diagnosis of Inebriety from Apoplexy.—Dr. Mills, in a recent clinical lecture on the case of a man picked up in the street unconscious, remarked as follows:

"This man has no external evidences of fracture; but sometimes without fracture or with concealed fracture, a sudden fall or blow on the head will produce an extra-dural or sub-dural hæmorrhage. Such patients are usually unconscious at first, and often regain or partially regain their senses, and again lapse into unconsciousness. One dilated pupil, convulsions, and some hemi-paresis, are among the prominent symptoms of such a lesion. The signs and symptoms present do not point clearly to this lesion.

"Other diagnoses to be considered are those of drunkenness, opium poisoning, epilepsy, uremia, and embolism or cerebral hemorrhage, perhaps still others, but these are the most important.

"Profound alcoholic intoxication can be excluded, as this patient is evidently absolutely unconscious, and suffering from profound paralysis, more marked on one side than on the other. In dead drunkenness, while consciousness may appear to be lost, the condition is rather one of extreme stupor or stupidity, and the patient by strong excitants can usually be made to respond in some way, although he may immediately sink again into his stuporous state. The smell of liquor on the breath may help, but this cannot be relied upon, as a patient insensible from any cause may have been drinking. Both sides of the body are equally affected in extreme alcoholic intoxication.

"Several facts will easily exclude opium poisoning, such as the sudden onset, the absence of pinpoint pupils which will not dilate, and the peculiarities of the state of insensibility. As the man was seen at the time of and immediately after his attack, and for others reasons, the post-paroxysmal sopor of epilepsy can be dismissed.—*Journal of Inebriety.*

The Changes in the Cardiac Ganglia in Acute and Subacute Endocarditis.—Kusnezow (*Archives F. Path. Anat. u. Phys. u. f. Klin. Med.* Bd. cxxxii, Hft. 1) concludes his lengthy and interesting paper as follows:

1. In acute endocarditis the observed changes in the cardiac ganglia occur in the form of inflammatory granulations, proliferation and swelling of the endothelium of the capsule, and albuminoid and fatty degeneration of the nerve cells.

2. The changes in the ganglia in the lower part of the auricular walls depend, in the main upon the extent of the process of granulation by continuity of tissue from the valves to the fatty tissue surrounding the ganglion.

3. Vacuolation of the nerve cells was not observed in acute endocarditis.

4. Pigment degeneration of the nerve cells of the heart is not always a physiological appearance, and does not always depend upon the age of the individual.

5. In hypertrophy of the heart, pigment accumulations in the protoplasm of the nerve cells is a common appearance.

6. The alteration of the cardiac muscle, in the majority of cases, stands in no constant relation to the changes in the cardiac ganglia.

7. Only in rare cases is it possible to establish a dependence of the power of the heart upon the diseases of the cardiac ganglia, in a pathologico anatomical manner, during life.—*University Med. Magasine.*

Interstitial Nephritis.—Huchard recommends the following for gouty cases with dyspnea, weak heart slight œdema, free urine, and very little albumen.

1. Exclusive milk diet for five days; ten ounces every two hours for six doses.

2. ℞ Ext. kolæ fl. . . . . ℥ ijss
Ext. cocæ. . . . . ℥ iv
M. S. ℥j at 8 A. M. and at noon, in the milk.

This is to counteract tne weakness.

3. If the milk disagrees, add a little Vichy, and five or six wafers, daily, each containing twelve grains of benzonaphthol and four grains of pancreatine. Or, a little rum, brandy, or cherry laurel water can be added to the milk.

4. Every succeeding month the patient is to be put on this diet for five days, to flush the kidneys.

5. For three days of each month give three pills daily, containing one grain each, of digitalis, scammony and squill.

6. After the milk diet give solid food, with plenty of milk. For some months give no meat, as this causes dyspnea.

7. Give iodide of sodium, as a heart tonic, gr. vi. to x. daily, for twenty days of each month.

8. Stimulate the skin by dry friction or liniments.—*Medical Press and Circ.—Times and Register.*

Glycerine in Constipation.—During my residence at the Stockport Infirmary I gave glycerine enemata in over a hundred cases, and on referring to my notes I find that the quantity injected was one drachm for children and two drachms for adults, the syringe used being the special one sold by instrument makers for the injection of glycerine. The bowels acted generally within fifteen minutes, in some rare cases half an hour elapsed, and on two occasions the injections had to be repeated. Since then I have discontinued the enemata and now I administer the drug by means of a suppository or "glycone," which can be obtained from any chemist at a small cost. The suppositories vary in strength, I believe, but some contain about 95 per cent of glycerine; and the results are the same as when the glycerine is given by enemata. These little suppositories can be most easily and quite painlessly introduced and the patients can themselves insert them. If one suppository fails to act in from five to twenty minutes, which is a rare occurence, the in-

troduction of a second will soon have the desired effect. Some of the advantages of glycerine administered by this method are absence of pain, ease of administration, rapidity of action and absence of griping. Glycerine suppositories are particularly useful in cases where an aperient by the mouth is not avisable. In midwifery practice, too, they are very useful for rapidly emptying the bowels. In the chronic obstruction of old people, caused by hardened fæces in lower bowel, glycerine suppositories are especially useful.—*Lancet.*

THE MINOR SYMPTOMS OF BRIGHT'S DISEASE (Dieluafoy.)—The catalogue of symptoms left us by Bright has been very much extended since his time. There is a convulsive form of uræmia, an apopletic form, a delirious form, which resembles somewhat insanity. Some patients have even been sent to insane hospitals. There is also uræmic headache; uræmic dyspnœa, which takes all forms, from the simplest up to the severest attacks, simulating asthma and acute pulmonary œdema.

We are still governed by the ideas of Bright and Rayer, and when there is difficulty in diagnosis, we look for albumen in the urine as the deciding symptom. If none is found we reject the diagnosis of Bright's disease. But Lancereaux has shown that albumen is an unreliable sign, since there are cases of true Bright's disease unaccompanied by albuminuria. Dieulafoy says: "For some years I have been taking notes of cases and have at present sixty observations. In a quarter of these albuminuria was wanting during the stay of the patients in the hospital. In other cases persons have albumen in the urine, without being ill at all; and this fact makes albumen only a minor sign in the history and diagnosis of Bright's disease. How, then, should we make the diagnosis? I have sought for some time for a certain number of symptoms, to which I have given the name of "minor signs," which, taken collectively, permit the diagnosis to be made. An individual attacked by this slow intoxication may present:

1. Auditory difficulties, ringing in the ears and deafness. Mounier has sought to bring the vertigo of Meniere's disease into this category.
2. Numbness of the fingers or hand was noted forty-six times in the sixty cases.
3. Chilliness of legs and feet observed thirty-seven times in the sixty cases.
4. Pollakiuria is equally common.
5. Pruritus, likened to the sensation produced by a hair on the skin.
6. Epistaxis, especially in the morning and starting during sleep.
7. The sign of the (temporal) artery. The arterial system is tense, the vessels are bent and hard (without there being arterio-sclerosis), and this is shown especially well by the temporal artery. Each of these signs separately has little value; but collectively are enough to form the diagnosis. These minor symptoms appear to be connected with three morbid conditions: Rheumatism or gout, syphilis and chlorosis. —*La France Medicale.—Times and Register.*

TROPICAL SUPPURATIVE HEPATITIS.—Surgeon Patrick Hehir, of the British Indian Service, formulates in the *Indian Medical Gazette* the following pathological classification of cases of hepatic abscess:

1. By far the most common are cases occurring consecutive to dysentery, and arising from a secondary infective process affecting the liver through the portal circulation. These cases arise from:

(*a*) The action of septic organisms, such as the streptococci, staphylococci, micrococci, or

(*b*) The irritation of the products of such septic organisms—ptomaines, conveyed to the liver from the ulcerated bowels and acting primarily on the liver, which plays the part of a filter upon the blood conveyed to it by the portal vein, or to the irritation of the amœba coli or cercomonas intestinalis, or both combined. Cases due to malarial poisoning, the blocking up of the radicles of the portal vein by the plasmodia of Laveran, these organisms acting as irritants and lighting up the suppurative process.

2. Acute sthenic parenchymatous inflammation resulting from climatic causes, overcrowding, alcoholic excesses, excessive heat or chill, acting upon a liver already in a partial state of disorganization.

3. Idiopathic cases in which no assignable cause can be traced.—*St. Louis Med. and Surg. Journal.*

ALBUMINURIA AS A RESULT OF THE ACT OF PARTURITION.—Modern obstetrics has done much to clear up the pathology of the gravid, parturient and puerperal conditions. Perhaps the greatest amount of discussion has centered about the condition that for the want of a better name is called eclampsia (*Med. News*). A knowledge of the etiology of this condition would practically mean also a recognition of the means of its prevention and treatment. Many clinicians admit that there may be a physiologic albuminuria as, for instance, after the taking of albuminous food and after active physical exercise. Recent observations by Aufrecht and Friedeberg (*Centralblatt für klinische Medicin*) demonstrate that transient albuminuria may occur in women as a result of the act of parturition. The observations were made upon healthy puerpera, free from gonorrheal infection, and were conducted as follows: The urine was examined in the usual manner before the onset of labor. In case the woman was in labor at the time of entrance into the hospital and was unable to spontaneously evacuate the bladder, the urine was withdrawn by means of the catheter, the most scrupulous aseptic precautions being observed. The urine was withdrawn by catheter at the conclusion of labor and again examined. In cases in which the urine presented an abnormality the examination was repeated twenty-four hours after the conclusion of labor. Thirty-two puerperal women were examined in the manner outlined. In none did the urine contain albumin before the occurrence of labor. In eighteen, however, albumin was found after labor in varying proportion; in none were tube-casts found, and in but one a small number of red corpuscles. It thus seems reasonable to infer that the albuminuria is a result of the activity of labor, perhaps through venous stasis from the pressure upon the abdominal viscera and forced expiration with closed glottis. The practical lesson to be learned is that the urine should be faithfully and repeatedly examined immediately before labor, and, if albumin be present, that untoward symptoms should be carefully looked for, on the appearance of which the labor should be terminated as quickly as possible. This injunction applies with special emphasis if eclampsia (which is almost invariably associated with albumin-

uria) has appeared. If artificial labor is not practical chloral hydrate is perhaps the most useful agent.—*St. L, Med. and Surg. Journal.*

Surgery.

Aneurism of External Iliac Artery. Ligation by the Trans-Peritoneal Method.—A woman, aged forty-eight, was admitted to the Leeds General Infirmary on September 22, 1892, suffering from aneurysms of the femoral artery. The first (the size of a large cocoanut) was situated in the right groin extending upward above Poupart's ligament; the second and smaller tumor occupied the middle third of the same (right femoral) vessel. The skin over the upper tumor was dark, very thin and threatened to give way. The posterior tibial artery could be felt pulsating very feebly, the veins over the dorsum of the foot were deeply outlined, and there was some œdema. The position of the upper aneurism prevented any of the usual operations being performed, and it was decided after consultation to ligature the external iliac artery through a median incision. On September 25, 1892, ether having been administered, the abdomen was opened in the middle line between the umbilicus and the pubes. The incision was at first four inches in length, but subsequently increased to six inches, owing to the great depth of the fat in the abdominal wall. The omentum was also very thick and greatly embarrassed manipulation. It was only after the pelvis had been well raised and emptied of the small intestines that a view could be obtained of the vessel. After ligature pulsation ceased at once. The portion of the vessel tied was quite healthy. So far as the abdominal conditions were involved the woman made a good recovery; beyond a little suppuration round one of the stich holes there were no drawbacks. The foot and leg, however, subsequently became gangrenous, and the thigh was amputated in the middle third. The patient lingered till December 11, when she sank. The necropsy showed the two separate aneurisms to be "true"; the lower one contained firm clot, the upper one was filled with dark liquid blood which did not clot. The vessels elsewhere were natural, as also were the organs generally.

Remarks by Mr. Brown.—Several instances of trans-peritoneal ligature of the external iliac artery have of late been put on record, and the general belief of those who have operated by this method appears to be that it is an easy procedure. I can only say that in this instance I had the greatest difficulty in obtaining, first of all, a view of the vessel, and, secondly, in passing the ligature. The patient was a very stout woman and the vessel was at a great depth from the surface; further, crossing the artery at right angles were three or four very full veins. When I saw them I felt that if wounded they would considerably hinder the operation by surrounding the vessel with blood. I quite think that this method of ligature is the one to be generally adopted; at the same time my individual experience does not coincide with that of others as to the facility with which it can be performed.—*Lancet.*

Charcot's Joint Disease (Arthropathia Tabidorum).—Dr. A. E. Sterne (*Medical Record*) says:

Arthropathia tabidorum and the spontaneous fractures which occur in tabes patients are trophic affections, due to a general disturbance of nutrition in a weakened organism.

They stand in near relation to tabes dorsalis, if not directly connected with that disease.

These affections have a characteristic stamp. They may be traumatic in origin; are so, however, only in the minority of cases.

They occur in every stage of tabes, yet seem to have a certain predilection for the pre-atactic period.

From a pathological-anatomical standpoint these affections should be considered in part as peculiar; their classification as arthritis deformans is not permissable. In part, however, they may be regarded as examples of the latter disease, and their commencement is often an intracapsular fracture.

The cause of these conditions is to be sought for in a degeneration of the peripheric nerves, a lesion probably constant in tabes. Furthermore, the neuritis of the spinal nerves stands to the sclerosis of the posterior columns of the cord as does the neuritis of the cranial nerves to the cerebral lesion.

The ataxy, the analgesia, and the fragilitis ossium are factors which influence considerably the course of these affections. They cannot, however, be looked upon as their causes. Each of these factors may be absent most readily the ataxy. This fails in reality in at least one half of all cases.

The therapy should be as conservative as possible. Recourse to surgical measures should be taken only in special instances.—*American Lancet.*

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Inoculation of Measles.—Dr. Hugh Thompson, of Glascow, inoculated nine children with fresh serum taken from blisters on patients suffering from measles. He believes that four were rendered immune, and that in two tne experiment failed. At the point of insertion of the serum slight measly-looking patches appeared in from one to two days and lasted for two or three days, accompanied with slight catarrhal symptons. The serum is taken from small blisters, no larger than a measly patch, and used immediately and inserted by superficial scarifications.—*N.Y. Med. Record.*

Removal of Epithelioma.—Dr. J. S. Wright, *Brooklyn Medical Journal*, reports the following interesting case. Captain B., seventy-three years of age, had an ulcerating epithelioma upon his right cheek, and was too feeble to take an anæsthetic. He lay down upon the operating table, and the electro-cautery knife was used to cut a circular furrow around the neoplasm, which had a surface a little larger than the thumb nail. Then the mass was ligated, as thoroughty as possible, by passing a strong ligature under its base in several directions. It sloughed away in a few days, and he left the hospital much improved, with the surface of the excavation granulating. He returned some weeks later exhibiting a nearly normal scar.

Syphilis.—Dr. Klotz, *Jour. of Cut. and Gen. Ur. Dis.*, in an article on the tertiary lesions of syphilis as the result of direct local infection, with general remarks on syphilis as an infectious disease, says:

1. Syphilis is caused by a microörganism similar to those of the acute exanthemata; the primary and secondary local manifestations are due to the direct influence of this parasite, the presence of which in

these lesions is proved by their contagiousness.

2. The general symptoms accompanying these stages and immunity are the result of the action of the toxines (Finger).

3. The microörganims, under the influence of their own chemical products or of treatment or in consequence of their natural innate character, are either eliminated or extinct or undergo some modification or produce a new kind of species of microorganism.

4. This secondary parasite, which is similar to the bacillus of tuberculosis, can indefinitely remain in the organism in a dormant condition until called into activity by some accidental irritation.

5. It then produces the tertiary, gummatous manifestations, but not the diffuse chronic visceral affections like tabes, general paralysis, etc., which are the result of intoxication with the toxines of the primary parasite.

6. The secondary microörganism is inoculable like the bacillus tuberculosis, and produces lesions identical with tertiary syphilis, but not primary syphilis.

7. Tertiary syphilitic manifestations may, therefore, be due to direct inoculation without the necessity of a primary or secondary stage.

TREPHINING FOR GUNSHOT WOUND OF THE BRAIN.—Prof. von Bergmann recently reported the following cases before the Berlin Medical Society. The patient, a man, aged twenty-eight, had attempted suicide several years ago by shooting himself with a revolver in the left side of the forehead. Attempts to extract the bullet were unsuccessful. Half a year later a painful swelling appeared over the bone, which after trephining and incision, proved to be a gumma and not an abscess, as has been suspected. The gummatous portion of the skull was removed, the defect becoming covered with cicatricial tissue. On March 11th of the present year, the patient again shot himself in the head. Three openings were found over the parietal bone, two being points of entrance and one being the point of exit of the bullets. Patient was admitted March 11th to Bergmann's clinic, and the day after became aphasic and somnolent. Three days after admission clonic spasms and paralysis of the right arm and hand developed. Trephining was performed and the bullet found beneath the point of entrance; the brain was lacerated at this place, but normal everywhere else. Numerous splinters of bone were removed and the bullet extracted. The wound was left open and the lacerated area of brain covered with iodoform gauze. Clonic spasms developed the night and day after operation, but soon disappeared and the further course was favorable, the paralysis disappearing after three days. The tampon was changed several times. Later a plastic operation for covering the granulation tissue was performed.—*Deut. Mediz. Zeitung.—Int. Jour. of Surgery.*

COMMINUTED FRACTURE OF SKULL.—I was called to see Samuel Salisbury, age 19, on March 9, who presented the following condition, viz: unconscious, the pulse and respiration slow and feeble, hemorrhage from a wound on the right side of the head about two inches above the ear. There was an opening through the skull into which I passed my index finger and distinguished several pieces of bone. I informed the father of the boy that it would be necessary to perform a delicate operation and requested that Dr. E. M. Moore be called. The wound was made by the kick of a horse two hours before, as he was leading him along the highway. There was a delay of seven hours before the operation, meanwhile the patient sank so low as to make it necessary to employ external warmth and stimulants hypodermically.

Under strict antiseptic rules, a button was removed with the trephine, and five detached fragments of bone; one of which penetrated the brain about an inch and a half, with the loss of about an ounce of brain substance. The following day consciousness slowly returned, but there remained complete paralysis of the left arm and leg. The dressings were removed on the fifth and eighth days, and subsequently they were renewed daily. There was moderate suppuration with hernia cerebri, and a temperature not above 101°, the wound closing on the thirty-fifth day after the receipt of the injury. Motion began in the paralyzed leg in twenty days and in the arm fourteen days later, and improvement continues. His mental faculties are impared.

Measurements of the head locate the wound at the junction of the areas of motion for the arm and leg, embracing the fissure of Roland. The symptoms following the wound were precisely such as would be looked for after an injury to this portion of the brain. As to complete restoration of function in the arm and leg, there seems to be an uncertainty. It must depend either on the reproduction of that portion of the brain lost, or the corresponding erea on the other side performing double duty. At at any event, four months have passed since the young man was injured and improvement has been continuous; so that he goes about without a cane and uses his hand to some extent.—*Armstrong in Times and Register.*

TREATMENT OF CYSTITIS.—Dr. Lavaux states that in cases of tuberculosis of the mucous membrane of the bladder, examination of the urine reveals, besides Koch's bacillus, other microörganism, especially the bacterium coli. The treatment of these secondary vesical infections is of great importance and must be undertaken with great care. Sublimate has little effect, but nitrate of silver is very useful if injected into the bladder in solutions of the strength of one or one and a half parts in a thousand, the injections being repeated every two or three days. If the secondary infection has extended upward, internal treatment must be employed besides the local.—*Internat. Klin. Rundschau.—Intre. Jour of Surgery.*

A SUCCESSFUL METHOD OF TREATING FOLLICULAR TONSILLITIS.—When I find a patient with the high fever and sore throat of follicular tonsillitis, I spend fifteen or twenty minutes in removing the exudate of the tonsils. I do this with the aid of three little instruments, viz: a small spoon such as is used in clearing out the meatus of the ear, an ordinary silver probe wrapped with a small piece of absorbent cotton dipped in peroxide of hydrogen, and a small forceps with which to sieze sticky masses not easily removable with the other instruments. My usual directions are to make frequent applications of peroxide of hydrogen to the tonsils by means of a brush, in addition to which I direct the use of the ordinary gargles and appropriate constitutional treatment. But my main reliance is in the topical treatment as described and after a single seance

with the patient I confidently expect to find a very marked improvement within a few hours, and am rarely disappointed therein. This treatment is usually repeated once or twice.—*Canada Lancet*, June, 1892.

Is not too Much Importance Attached to the Condition of the Tonsil?—It is my experience that treatment of the nose and post-nasal space is productive of more good to the pharynx and tonsils than treatment of the tonsils is to the nose and post-nasal space, and I am glad to believe that the days of wholesale slaughter of large tonsils, without regard to structures higher up, will some day have an end.

Without undertaking to go more deeply into the subject may we not draw the following conclusions:

1. Because the tonsils are easier to see than the nose and post-nasal space is no sign that they are more important than the latter.
2. Form no estimate of the size of the tonsils unless you see them in repose.
3. Always examine the back teeth and the base of the tongue.
4. In acute follicular disease of the tonsils, look for and treat disease of the other follicular tissue in the throat.
5. Nasal obstruction, cough, and impaired voice are much more likely to be due to nasal or post-nasal hypertrophy than to tonsillar.
6. The fact that the tonsils are enlarged or diseased should lead us to look for a possible explanation in the parts higher up.
7. Free the nose and the post-nasal space in addition to, or instead of, tonsillotomy, if you wish to improve the voice and respiration.—*Boston Med. and Surg. Jour.*

New Method of Penetrating the Antrim of Highmore.—Moure claims to overcome the objections of all the other methods by the following procedure: An area of the pitutiary membrane beneath the inferior tubinated bone is cleansed and anæsthetized with cocaine, and then by means of a galvano-cautery tip placed against it, the current is passed interruptedly. The tip quickly penetrates the antrum.

After operation a small canula is placed in the opening. This is easily done, as the opening can be seen, owing to the retractile effect of the cocaine on the tissues. There is no loss of blood and no fear on the part of the patient. Moure prefers a sublimate solution 1-5000 for lavage of the cavity.

He acknowledges, however, that in some cases penetration by this method is difficult—even impossible. This may be owing to the thickness of the bony wall or to the existence of a bony column at the site of operation.

In these cases all that the cautery can do is to remove the mucous membrane and so prepare the way for the application of the trochar.

The caution is added that puncture by any method should be left as a last resort, for this procedure, if undertaken in patients with a purulent rhinitis, will aften set up an empyema of the antrum, and that too in spite of all antiseptic precautions.—*Gaz. Hop. de Toulouse, Epitome.*

Mackenzie (G. Hunter) on Tonsillotomy, with an Analysis of 230 Cases.—The ages of the subjects ranged from that of slightly under two years to those of fifty years of age. Profuse or troublesome hæmorrhage never followed any of the operations, and the author believes there is little danger from this source, if care be taken to leave a cleanly cut surface and not to injure the faucial pillars or soft palate.

Results.—In children the local and general results were without exception most beneficial, and the younger the child and the larger the tonsils, so much the more satisfactory was the after-condition of the patient. In two cases only (males aged seven and ten years) the tonsils reënlarged, the one seven months and the other two years after the operation, and excision had again to be performed. In three adults the tonsillar stumps became inflamed in periods varying from three to fifteen months, and in one instance an acute abscess formed two years after the tonsils had been removed. It is right to remind the reader that in children these results in several instances were not attained by removal of the tonsils alone, but, in addition, by curetting or scraping the naso-pharynx and posterior nares, and galvano-cauterizing the anterior nares in cases in which obstruction of these regions existed. Such were almost exclusively under ten years of age, with the marked respiratory and other troubles already referred to, and in no single instance was there failure to give marked relief.

The operation did not appear to be quite so successful in regard to the removal of the deafness which occasionally accompanies tonsillar enlargement, though in some instances this was remedied, especially when the operation was supplemented by treatment of the naso-pharynx.

The author feels satisfied that the operation is neither bloody nor barbarous, and that its results will stand comparison with most of the other surgical procedures of the present day.—*British Med. Jour., Epitome.*

Treatment of Loss of Sexual Powee by Ligation of Veins.—The loss of sexual powers, says Dr. Alfred King (*Boston Medical and Surgical Journal*), or rather deficient erections of the penis, render so many men miserable mentally and physically, that any new method of treatment, promising a radical cure, merits investigation and trial:

Three immediate causes of deficient erections may be specified: destruction of the erector muscles, loss of nerve power, and a change in the circulation. The first of these is so rare and so easily determined that it needs only a passing notice. The second cause, loss of nerve power, seems to me to have received more prominence than it deserves, as it is the basis on which almost all treatment is founded. While its force in many cases is undisputed, yet the frequent failure of treatment based upon it leads me to direct attention to the importance of the third cause, that is, a change in the circulation. This change takes place in the viens, especially those which do not pass beneath the pubic arch, or are not acted upon by the erector muscles. Repeated engorgement of the penis renders their caliber larger and, consequently, there is a more rapid escape of blood through them. When therefore, an erection takes place, it cannot be maintained on account of the escape of blood through these channels. Thus we have the history of a gradual shortening of the duration of erections, and finally, scarcely none if any, as these veins grow larger.

The remedy for such a condition, especially when far advanced, is not in the use of drugs, but may be brought about speedily and safely by the ligation of some of the larger of these veins.

The following case is given to illustrate this cause and its successful treatment:

Mr. M., aged thirty-five, a laborer of powerful physique, came to me about a year ago with the following history: For several years he had been losing the power of maintaining an erection; during the past year its duration had been so short that sexual intercourse had been rendered impossible. There was a loss of sexual desire and great mental depression. Excessive use or abuse was the cause of this condition.

I gave all possible encouragement to the patient; advised total abstinence from sexual intercourse, cold baths, (especially to the spine and external genitals); prescribed bromides, cannabis indica, cantharides, damiana, phosphorus and salts containing it; pushed strychnine as far as it could be borne; gave various tonics; used electricity; and in short did everything which offered any hope of success, but all to no effect so far as producing any stronger erections was concerned.

Careful study of the case convinced me that the immediate cause of the trouble was a physical one, due to a leakage, as it were, or to a too rapid escape of blood from the penis when erected. I, therefore, determined to ligate a couple of the larger subcutaneous veins at the base of the penis and watch the effect.

This was very easily done by the use of cocaine. A vein on each side of the penis was exposed, ligated in two places and severed between the ligatures. A dressing was lightly applied and held in position by a strip of adhesive plaster placed longitudinally. The result was immediate. In less than five minutes after leaving my office he had an erection. That night he was awaked by a powerful erection which made the bandage so painfully tight that he was obliged to jump out of bed onto the cold floor to subdue it. Primary union was prevented by the frequent erections, but the success of the operation was certain.

Two months later he reported himself well, mentally and physically, his sexual appetite had returned and since the operation his power of maintaining erections had been as good as ever.—*Med. and Surg. Reporter.*

Rational Treatment of Furunculosis.—Dr. Th. Rovsing (*Hospitals-Tidende*, No. 15. 1893) finds the successful treatment of boils to consist in isolating the first one and not permitting it to spread over the surrounding skin and thus giving rise to a crop of these pests, very painful and trying on the back of the neck. He does not poultice, but incises the furuncle, presses out the pus, and covers the opening with a piece of absorbent cotton, fastening the edges by means of collodion, and leaving the air ingress through the center that it may exercise its drying influence.

Total Ablation of the Ureter after Nephrectomy.—In *L'Union Medicale*, February 18, 1893, p. 248, is the report of a case in which Reynier, after performing a nephrectomy, later excised the ureter. He believes it to be the first operation of the kind performed. The kidney was removed for abscess which had destroyed its tissue. Pus still continued to make its appearance in the urine, so that six months later he made an incision such as is made for the ligature of the common iliac artery. The fistula in the loin aided in finding the ureter. This was followed down and ligated close to the bladder. It was then removed. The patient, a young soldier, left the hospital cured. In the discussion Championnière said that of all the nephrectomies he had performed there had never been a single case of fistula following. Terrier had had the same experience, he always taking good care to fix the ureter in the wound to avoid infection.—*Univ. Med. Magazine.*

Paracentesis in Hydrothorax.—In the *Gazeta Lekarka*, No. 12, 1893, p. 320, Dr. Kasimir Chelchowski, of Warsaw, details a very interesting case of a mill-worker, aged 51, in whom the chest was tapped as many as *fifty three* times in the course of the last twelve months of his life, the man suffering from aortic insufficiently, with right-sided hydrothorax. From one to two and a half liters of serous fluid were removed on each occasion, the specific gravity at first averaging 1009, but subsequently rising to 1012, and even to 1013 or 1014. As a rule thoracocentesis was resorted to satisfy the *indicatio vitalis*. Fairly frequently, however, the author felt compelled to undertake the operation, solely in view of the patient's most urgent requests; the man even threatening that otherwise he would tap his chest by means of a jack-knife. The procedure was invariably followed by a very marked relief of dyspnœ, and other subjective phenomena. During the same period the patient underwent eleven distinct courses of a diuretic calomel treatment. In the beginning the effects were very pronounced, dyspnœa and œdema disappearing in some three days. Later on, however, the drug's action became even weaker, even a much larger administration of much larger doses failing to secure satisfactory results. The post-mortem examination revealed dilatation of the aorta and diffuse antheromatous degeneration of its wall and valves.—*St. L. Med. and Surg.*

Spinal Concussion.—In the *Medical Age* Dr. C. H. Wilkinson presents an exhaustive study of this condition and offers the following conclusions:

1. In reality, spinal concussion is a temporary condition and ordinarily of brief duration, lasting a few hours, or days at most.

2. Authors have erroneously considered under this heading many of its consequences, such as the psychoses and secondary inflammation of the cord and its membranes.

3. For the sake of convenience only, and in order to be in fashion, I have included under "concussion" the primary shock as well as the subsequent sequences after spinal injuries.

4. Spinal concussion, as thus considered, has no demonstrable pathology attached to it, and all secondary inflammations should be designated as myelitic or some variety of meningeal inflammation, and should be treated as such.

5. In this disease the injury is thrust upon the sympathetic system of nerves, through the perceptive centers of the brain; and not through any inflammatory process of the cord; so that persons asleep or intoxicated at the time of an accident, and those whose attention is riveted upon some grossly injured

member of the body, are always the lightest sufferers after such accidents.

6. In its nature, spinal concussion is a true hypochondriasis, and is kept alive by morbid suggestions and evil forebodings from self and others, as well as perpetuated by a lack of self-confidence and a neglect of proper exercise, both physical and mental.

7. Being a disease with few if any objective symptoms, it is often the avenue adopted by malingerers to claim pecuniary reward for home manufactured injuries.

8. Absolute rest after injuro, and mental diversion with light bodily exercise (especially remunerative exercise) in the secondary stages, are the best means known for averting chronicity and warding off incurableness in spinal concussion.

9. Where the foregoing methods are properly carried out the prognosis in this disorder, both as to life and future usefulness, will be very good.

Therapeutics.

Nasal Hydrorrhœa.—In the *N. Y. Med. Journal* Dr. G. F. Keiper reports the following case:

F. B., an architect, consulted me on May 7, 1892, on account of a constant and profuse discharge from his nose which, on account of his occupation, was most annoying. Nothing in his previous history could account for it.

The nares upon examination presented all the characteristics of hypertrophic rhinitis. Treatment was immediately instituted for the reduction of the hypertrophied tissue, but after six months' faithful treatment the discharge continued unabated. All of the remedies ever suggested for relief of similar cases failed here, cocaine included.

After considerable thought upon my patient's condition, I ordered the following:

℞ Atropine sulph..... .....gr. ij;
Aquæ dest.....ʒ j.

M. Sig.: Spray each nostral morning, noon and night.

Within two days the discharge markedly lessened and since then has been in normal quantity only.

The patient suffered some inconvenience at first on account of getting some of the solution into his eyes, but by due caution he has had no trouble since, though he still uses the atomizer.

The Drip Sheet.—In a recent address before the New York Academy of Medicine (*Medical Record*), Dr. Weir Mitchell gives the following directions for the use of this agent by persons needing the modified rest cure:

"What I dread most at the start, in all cases for rest, is grave insomnia. Whether it be accompanied by a state of mild mental excitement such as we all know, or is a pure incapacity to go to sleep or to stay asleep, or whether it be in popular medical belief a congested state, I am apt at once in bad cases to use twice a day lithium bromide, at first in thirty-grain doses, at noon, at 6 and 9 P. M., given in the malt or not, and soon decrease grain by grain. If I want a positive aid at bedtime, I prefer sulfonal in hot water. But of greater value are some of the hydro-therapeutic devices—and best of these is what is known, or not known, as the "drip sheet." Just how this is to be given is of the utmost importance. The following memoranda must answer to show how careful one must be in my opinion, as to these details. I give it here, in brief, much as I do to the patient not under the immediate care of a nurse. I cannot help adding that several of the most useful of the water processes are neither taught in our schools, nor so accurately in hydro-therapeutic text-books as to be of much value to the general practitioner.

Memoranda for Use at Bedtime of Drip Sheet.—Basin of water at 65° F. Lower the temperature day by day, by degrees, to 55° F. or to still less. Put in the basin a sheet, letting the corners hang out, to be taken hold of. The patient stands in one garment in comfortably hot water. Have ready a large, soft towel and iced water. Dip the towel in this, wring it, and put it turbanwise about the head and back of the neck. Take off night-dress. Standing in front of patient, the basin and sheet behind, the maid seizes the wet sheet by two corners and throws it around the patient, who holds it at the neck. A rough, smart, rapid rub from the outside applies the sheet everywhere. This takes but two minutes or less. Drop the sheet, let the patient lie down on a lounge upon a blanket, wrap her in it. Dry thoroughly and roughly with coarse towels placed at hand. Wrap in a dry blanket. Remove ice wrap, dry hair, put on night-dress. Bed, the feet covered with a flannel wrap.

If all this seems to you, as you read it, too absurdly minute, I shall feel some regret. Yet believe me, it is worth the trouble, and the drip-sheet is a remedy past praise. If it fail, a pack may succeed; but this is more familiar to you. I doubt if the use of the drip-sheet is as well known".—*Med. and Surg. Reporter.*

Terpene Hydrate in Bronchial Catarrh.—Dr. Wm. Murrell (*Med. Age*) says:

I am desirous once more of calling attention to the value of terpene hydrate in the treatment of affections of the bronchial and nasal mucous membranes. Its properties have been well known for many years, but in this country it has never been a popular remedy, and its claims seem to have been overlooked in favor of pure terebene and other similiar compounds. It is a hydrate of turpentine, and is made by treating oil of turpentine with nitric acid and alcohol. It is a solid, and has somewhat the appearance of chloral hydrate. Its oder, which is slight, resembles that of pure terebene. The great difficulty in the way of its administration is that it is practically insoluble in water. It is usually said to dissolve in alcohol in the porportion of 1 in 10, but many specimens are far less soluble. On the continent, where it enjoys a high reputation in the treatment of bronchial affections, it is used as a popular remedy in the form of an elixir. For some months past I have prescribed it in a solution containing five grains to the half-ounce, made up with simple elixir and flavored either with tinture of Virginia prune and syrup of tar or with aqua laurocerasi. For patients who cannot take sugar the elixir may be made with saccharine. Terpene not only relieves cough and lessens bronchial secretion, but is a diuretic, and has been used to advantage in neuralgia.—*Med. & Surg. Reporter.*

Oily Sprays For Nasal Affections.—The action of menthol, camphor, thymol, and the volatile oils, sprayed in oily solutions upon the mucous membrane

of the upper respiratory tract is easily studied. They are at first stimulating, increasing capillary circulation, and later they are soothing, sedative, or antiphlogistic, since their quick evaporation is only effected with and by the rapid abstraction of heat from the tissues, a chilling of the surface, a contraction of the peripheral circulation. In this sense they might almost be termed astringents. If these rapidly evaporating drugs are sprayed into the nasal chambers for a long time, they certainly do contract distended turbinated tissues and diminish secretion as well, and eventually what is called a "cure" may be effected. It is not wise to continue the use of the strongly volatile preparations too long, for they produce a dryness of the surface (and this is especially true of the pharnyx) which is almost as annoying as an atrophic condition. I rarely use oils with an up spray against the middle or upper pharnyx. These volatile preparations are very grateful and cooling in painful inflammations of the larnyx, as in subacute laryngitis, in the swollen arytenoids of tuberculosis, and in the ulcerative conditions of phthisis and syphilis. I aimost always follow astringent applications of zinc, silver, iron, etc., with a soothing oily spray.—Rice, *Post Graduate.*

Caffeine-Chloral in Chronic Constipation.—Professor Ewald, of Berlin, has made use at the Augusta Hospital of a combination of the two drugs named in the heading. He has found it valuable for the treatment of constipation, when the compound is administered subcutaneously. He has made use of injections of four or five grains dissolved in water, and he has only failed once in thirteen cases of obtaining, as a result, thin stools; in some of these cases the ordinary drugs and free irrigation had been used without avail.

Ewald has also used the compound in a small number of rheumatic cases that had been resistant to the salicylates. In seven out of eight cases the injection of from three to six grains in twenty-four hours has been followed by reduction of pain and swelling in the affected joints. These injections, according to the information given in the Berlin correspondence of *Notes on New Remedies*, are usually not attended by any pain, although in a few cases there was a slight burning sensation at the point of the injection. The well-known, but not very uniform laxative action of caffeine appears to be intensified by the presence of chloral in the compound. If this is a fact, it would seem to be contradictory of certain experiments on the lower animals that have been reported as showing that caffeine, in the presence of chloral, is almost wholly masked. Urea and cyanogen, in like manner, are said to be masked when given with chloral. However it may be as to the overmastering agency of chloral with other substances than caffeine, it seems to be an indisputable fact that caffeine-chloral has a therapeutic future before it in the treatment of chronic constipation.—*N. Y. Med. Journal.*

Jambul in Glycosuria.—Vix (*Therap. Monatshefte*, April, 1893) has employed a fluid extract of jambul bark as a substitute for the fruit in diabetes. This preparation is less costly, more pleasant to the taste, and quite as efficacious though less prompt in its effect.

Two cases of diabetes are described, in which there was no marked polyuria, but in which the amount of sugar excreted was 7 per cent and 3 per cent respectively. An anti-diabetic diet was employed during treatment. In the first case 10 drachms a day or 9 ounces in all were sufficient to render the urine normal for two years, when the patient died of influenza and pleurisy. In the second case the disease had lasted three years, and the symptoms entirely disappeared after a few days' treatment.

The results were confirmed in ten other cases, the urine always showing improvement. Vix has never observed any unpleasant effects from the drug, and believes it to be of the utmost value in conjunction with general diabetic and hygienic treatment. He recommends that the drug be given with or after meals, in water or wine sweetened with saccharin, the former being changed to a dark red color. This coloration is occasionally imparted to the urine and stools.—*Univ. Med. Maga.*

Treatment of Diarrhœa by Electricity.—Dr. Ervant Arslan, formerly assistant to Dr. Jules Simon at the Hospital des Enfants-Malades, of Paris, reports to the Société de Biologie on the application of the faradic current directly to the abdominal wall in bowel disorders of children. In fifteen cases he had successfully resorted to this procedure with remarkable success in promptly controlling both diarrhœa and vomiting, no other remedies being given. In three cases of cholera in infants the electric current was used in this manner with complete success in each case. Two of them received at the same time other treatment, but the third, in whom the symptoms were the most grave, was subjected solely to electricity. The diarrhœa in all rapidly ceased, but the vomiting continued until the current was sent along the pneumogastric, by placing one electrode over the vasculo-nervous tract in the neck, and the other upon the epigastrium for a minute or two at a time. The vomiting then ceased and did not recur. The general symptoms also began to ameliorate, and the patients were convalescent in three or four days.

The current from any induction apparatus will answer the purpose; it should be strong enough to produce contraction of the muscular fibers. The electrodes should be frequently moistened and applied in various locations over the abdominal surface. One application, early in the morning, each day, is usually sufficient in ordinary diarrhœa; in graver cases, and in cholera, the current may be applied twice in the twenty-four hours. In some cases a single application is sufficient to check the further progress of the malady; the diarrhœa may even be succeeded by constipation, as in one of the cases referred to.

In general, after three or four applications at most, the diarrhœa stops and other symptoms are mitigated.

Exceptions to this are found in diarrhœa due to dysentery and ulcerative entero-colitis. In other forms this method gives excellent results, even in the diarrhœa of phthisis, and this may be so held under control as to permit increase of nutrition and of the strength of the little sufferers. It is possible that this mode of treatment may also prove applicable to adults. It has, at least, the advantage of not interfering with other remedial or dietetic measures which may be deemed proper or necessary by the physician in charge of the case.—*Jour. of Balneol.*

The Treatment of Diabetes.—Harley (*British Med. Journal*, May 27, 1893), after speaking of the

remedies generally employed in diabetes, such as opium, morphine, codeine, hyoscyamus, cocoaine, bromide of ammonium and the like, calls attention to the value of croton chloral. He says: "The beneficial effects of croton chloral often surprise me, but I seldom ever give it except in combination with a vegetable narcotic or anodyne. . . . To give a single formula that will answer in every case of a protean disease like diabetes is, however, out of the question, so all I will do is to give the one employed in the case just alluded to. It is the following: ℞. Croton chloral, gr. ½; opii. gr. i.; ext. aloes barb., gr. ⅙; ext. gentianæ, gr. iss. M. One pill to be taken three times a day."

In cases of diabetes resulting from nervous exhaustion, as well as those arising from pancreatic disease, he states that he found extract of nux vomica in ¼ gr. doses three times a day in a croton chloral pill of great service. In such cases remedies tending to improve the general health, notably phosphoric and nitro-hydrochloric acids, are of service. He has found antipyrin and peroxide of hydrogen very useful in one or two instances.—*Univ. Med. Maga.*

The Psychotherapic Treatment of Morphinism.—Dr. E. Berillon, in the *Journal of Inebriety*, says: From our personal observation we believe ourselves able to deduce the following conclusions:

1. If the distinction that writers have tried to establish between simple morphinism and morphinomania presents a certain interest from a clinical and medico-legal point of view, it offers only a secondary interest from a therapeutical standpoint.

2. In both cases psychotheraphy, that is to say, the employment of hypnotic suggestion, in the majority of instances, effects a complete cure without recourse to isolating patients in a special establishment.

3. In the cases where isolation is judged necessary, psychotheraphy facilitates the treatment by diminishing very appreciably the pains and various troubles due to the abstinence.

4. The difficulty in the demorphinization of a patient does not at all correspond with the mental troubles which he may present, nor with his poor physical condition at the moment of the commencement of the treatment. The difficulty results above all from the default of energy of the patient and his irresolution to cure himself.

5. The duration of treatment is about one month. The morphine should be gradually suppressed. When the patient decreases to two or three centigrammes per day, the suppression should be radically made. At this time the suggestive seance should be repeated more often to combat the malaise and sustain the energy of the patient.

6. The period of convalescence is less long when the suppression has been more slow. During some months after the total suppression, the malaises which frequently trouble the patient are easily dissipated by suggestion.

7. The cures obtained by the employment and with the aid of suggestion are much more sure than those obtained by a forced suppression. They have for a base the awakening of the patient's will, and the putting into play of this will is the surest means of preventing a relapse; moreover, it is possible by suggestion to inspire in certain persons a positive disgust for morphine.

Nucleine.—At a meeting of the Academy of Medicine, M. Germain Sée made a report concerning his study of a new medicament, nucleine. Derived at first from the nuclei of cells, it has latterly extracted from other substances, such as the pulps of the spleen, the yelk of the egg, and ill digested caseine. Its characteristic is the presence of phosphoric acid, which distinguishes it from other albumens. It is a colorless or yellowish powder, insoluble in water and alcohol, soluble in weak alkaline solutions and in water after long boiling. Administered in the daily dose of thirty to forty-five grains, it is inoffensive, but produces a considerable increase of the white corpulcles. This increase of the phagocytes explains the good effects of nucleine in pleurisy, pneumonia, and other infectious maladies.

M. Sée made allusion also to the very useful diagnostic property of nucleine in latent tuberculosis. In tuberculous subjects, and in those alone, nucleine produces a fever reaching 104° F., and lasting two or three days, and a congestion of the apices. These troubles are evanescent, and are followed by no deleterious effect. In children too young to expectorate,—the search for the bacilli being, therefore, impossible—nucleine may be an assistance when a diagnosis is doubtful.—*Le Progrès Médical.—Bulletin.*

Vegetable Essences as Antiseptic Dressings.—At a meeting of the Surgical Society, M. Lucas-Championnière remarked that, like every one else, he had tried to find a substance capable of replacing the antiseptics now in use, which were attended by the inconveniences of being toxic and irritant. At length he had made use of the essences so well studied by M. Chamberland, who had shown that they possessed an antiseptic power next to that of sublimate. It was the essence of cinnamon, which was especially made use of by M. Championnière. Applied full strength upon wounds it proved to be very irritant. The idea then occurred to dissolve it in retinol, which made a pomade of good consistence. This pomade, spread upon gauze and applied upon sutured wounds (amputation of the breast, fingers, etc.), constitutes an excellent dressing. It is not irritant, and beneath the pomade the wound remains aseptic and cicatrization goes on in a perfect manner. The other essences, those of geranium, thyme, vervain, etc., possess the same properties.—*La Tribune Medical.—Med. Bulletin.*

Dermatol in Diarrhœa.—Colasanti and Dutto (*Bulletino della R. Accad. Med. di Roma*, xvii, 8, 1892), claims that dermatol is one of the best remedies in the modern therapeutics of diarrhœa. They state that good results were obtained only with the dermatol prepared by Hœchst. The remedy was employed in diarrhœa of several varieties:

1. In 100 cases of colliquative diarrhœa of phthisis the results were remarkable. As a rule the daily dose was thirty grains, in four powders, but in severe cases this amount was increased to ninety grains daily. Its administration caused no disagreeable results.

2. In the diarrhœa of typhoid fever the results were as satisfactory during the febrile period as during convalescence.

3. Ten cases of ulcerative entero-colitis, which had entirely resisted all other medication, were entirely cured by dermatol.

4. In six cases of diarrhœa of malarial origin the results were rapid and definite.

5. The diarrhœa attending the convalescence of acute febrile diseases also responded favorably to the drug. G. Caruso-Pecoraro and S. Tomasini also testify to the value of dermatol, in daily doses of fifteen to sixty grains, in several varieties of diarrhœa. —*Univ. Med. Magazine.*

THE THERAPEUTIC EFFECT OF HIGH ALTITUDES.—C. Theodore Williams, in a lecture delivered before the Royal College of Physicians, London (*British Medical Journal*, April 1, 1883), states that his studies of the effect of high altitudes on phthisis warranted the following conclusions:

1. Enlargement of the thorax takes place unless opposed by the growth of fibrosis, or by extensive pleuritic adhesions.

2. Males and females seem to do equally well, and profit most between the ages of twenty and thirty, males over thirty and females under twenty benefiting least.

3. The climate is specially beneficial in hæmorrhagic cases and in hereditary cases, and appears in the latter class to exercise a distinctly counteracting influence on the development of phthisis.

4. It is most effective in cases of recent date, though of utility in those of long standing, and to insure its full benefit at least six months', and in many cases two years', stay is desirable.

5. With regard to the actual results of the climate, it undoubtedly produces great improvement in seventy-five per cent of cases of phthisis generally, and in forty-three per cent it causes more or less complete arrest of the tubercular process.

Its beneficial influence is best shown on tuberculous consolidation, where improvement may be looked for in eighty-seven per cent, and arrest in fifty-seven per cent. Arrest takes place in sixteen per cent of the patients with excavations, and great improvement in fifty-five per cent. High altitudes also prove beneficial in:

1. Imperfect thoracic and pulmonary development.
2. Chronic pneumonia and bronchiectasis.
3. Chronic pleurisy, where the lung has not expanded after removal of the effusion.
4. Acute phthisis of all kinds, and especially where there is great irritability of the nervous system.
5. Phthisis with pyrexia, and in pyrexial cases generally.
6. Emphysema.
7. Chronic bronchitis and bronchiectasis.
8 Diseases of the heart and great vessels, except functional ones; diseases of the liver and the kidneys, incuding all forms of albuminuria (Andrew Clark).
9. Diseases of the brain and spinal cord, and conditions of hypersensibility of the nervous system.
10. Anemia.
11. In patients of advanced age or too feeble to take exercise.—*Univ. Med. Magazine.*

BENZO-NAPHTHOL IN BACTERIAL INTESTINAL DISEASES OF INFANTS.—Menthol benzoate was used with marked success by Moncarvo (Rio de Janeiro) to arrest intestinal fermentation in children of all ages, especially in diarrhœa of malarial origin. The drug was tolerated very well, and the benzoic acid formed from the decomposition of the remedy in the system was eliminated by the kidneys in the form of hippuric acid, and consequently it must act as a diuretic. The dose varied from four to twenty-two grains according to size and age. In rebellious malarial diarrhœa, the addition of equal parts of salicylate gives excellent results. The writer has used benzo-menthol with benefit in yellow fever.—*Modern Medicine.*

TREATMENT OF UREMIC CONVULSIONS.—Bloodletting should be confined to acute, sthenic cases, if used at all.

Chlorform will stop convulsions but is dangerous and treacherous. No one now thinks of giving ether. Opium is preferable to bloodletting, but only lessens nerve irritability. It has no equal for lesser uremic symptoms, dyspnea and palpitation. Pilocarpine may be used in the intervals, to cause sweating. It is a dangerous cardiac depressant. Veratrum viride with opium I have used for two years with uniform success. Give the morphine hypodermically and at once follow by injecting Norwood's tinture, m v—x. The fits soon cease and do not recur. The pulse falls to 30, without harm. This drug is also prophylactic. —Page, *N. Y. Polyclinic.*

TO PREVENT COCAINE INTOXICATION.—Dr. Parker, in the *British Medical Journal*, writes that the unpleasant and dangerous effects which occasionally follows the local application of cocaine can be prevented by combining it with resorcin, thus also obtaining the astringent, antiseptic and hæmostatic properties of the latter drug.

Diseases of Women.

THE INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES.—In an article in the *Medical and Surgical Reporter*, Dr. Marie J. Mergler concludes that the appendages should be removed for

1. Existence of neoplasms in the appendages.
2. Hernia or prolapse of the ovary, when irreducible and when producing urgent symptoms which do not yield to palliative treatment.
3. To the arrest of the growth of uterine fibroids. Here the limits can hardly be said to be definitely fixed. As a rule, however, the operation may be taken into consideration for tumors which are sub-mucous or interstitial, before the uterus has attained a great size (Olshausen puts it at the size of a four months pregnancy). It may also be considered in fibroids when the symptoms are urgent and when either on account of cardiac weakness or from the presence of nephritis, so common in fibroids, the more radical though more dangerous, operation of laparo-hysterectomy would be attended with too much risk.
4. Inflamed conditions of the appendages, whose symptoms render the patient's life a burden, and which have resisted a fair trial of palliative treatment. These conditions when complicated by extensive adhesions of the organs, are less likely to yield to mild measures. Even in these cases the breaking up of firm adhesions, after abdominal section without removal of the ovaries and tubes, has been followed by relief of the symptoms.
5. The presence of pus in the ovary and encysted pus in the tube, as a rule require the radical treatment.

b. Marked reflex neuroses whose origin may be traced directly to diseases of the appendages.

SUDDEN DEATHS IN CONFINEMENT CASES.—Not long since a case came to our notice in which a woman was having an enormous *post partum* hæmorrhage. With the first gush of bright red arterial blood through the vagina, the medical attendant became quite rattled, and, of course, at once attacked the uterus, stuffing its cavity firmly with antiseptic gauze, and then commenced to inject beef extract up the rectum, that she might make blood for what she was losing. But, seeing that his patient was fast sinking, and that he was powerless to control the flow, a consultant was sent for. On his arrival, he at once removed all the uterine packing, caught the neck of the uterus and pulled it into the vagina, when there, by the aid of a candle, he saw an enormous laceration up its inner wall, which tore the left uterine artery in two. In an instant the bleeding vessel was in the safe grip of a hæmostatic forceps; a life had been saved.

We are acquainted with another somewhat similar case. The woman had a normal labor, but a free hæmorrhage promptly followed. Now the medical attendent at once ordered ergot, carried a lump of ice up the uterus, then packed its cavity with a sponge soaked in vinegar, kneaded the surface, and poured pitcher after pitcher of ice water in, but all to no effect, as the bleeding continued.

As the woman was becoming desperately weak, they hurried for a consultant. On his arrival he inquired as to the color of the blood. They told him that it was a tarry black. He in a moment allayed their fears by telling them that it would not be a mortal hæmorrhage, and that he believed he could easily arrest it. We can imagine the chagrin of the family physician, as the consultant, with his speculum, showed him that there was not a drop coming from the uterus, with all its tamponage removed, but that it entirely escaped from a large rent in a vaginal varix, which, with a pin and a piece of thread, he transfixed and secured in a moment.

Vinay, in the *Tocological Archives* for April, discusses at considerable length, in a highly valuable contribution, the many and complex factors which enter into the etiology of sudden deaths in labor. Many of them, he says, may be prevented, while not a few are hopelessly mortal. In any event, in all cases of obstetrics, the attendant must be always on his guard for the signal of danger, so that, appreciating its significance, he may anticipate and perhaps wholly obviate it.—*Times and Register.*

VENESECTION IN OBSTETRICS.—Dr. William B. Dewees concludes a study of this subject, *Jour. of Mat. Med.*, with the following statement:

Venesection at the time of parturition in certain plethoric morbid condition, is a safe, easy, prompt and effectual means of

1. Relieving the sufferings of parturition.
2. Relieving the rigidity of the os uteri, perineum and adjacent soft parts.
3. Facilitating the delivery of both the child and the placenta.
4. Preventing irregular or spasmodic contractions of the uterus.
5. Preventing such accidents as have occurred from rigidity of the os uteri, the perineum and adjacent soft parts, and the irregular spasmodic contration of the uterus, namely: Rupture of the uterus; laceration of the cervix, perineum and sphincter ani; protrusion of the cervix before the head of the child, which in some cases had to be divided before delivery was effected; inflammation and gangrene of the soft parts from the long pressure of the child's head, by the prolonged frequent and repeated violent contractions of the uterus; atony of the uterus, which have succeeded even after the solt parts and os uteri yielded and the child was delivered by instrumental aid a hemmorrhage supervened which frequently proved fatal.

In short, to say nothing of the injuries inflicted upon the child, when we add to these the risk of convulsions and rupture the of blood vessels, all of which have happened and may again happen under similar circumstances, we cannot conclude without again raising a voice in favor of venesection as a most valuable aid in relieving and preventing the sufferings and conditions here enumerated.

PUERPERAL SEPSIS.—In an article on this subject, *Buffalo Medical and Surgical Reporter*, Dr. William Warren Potter offers the following conclusions:

1. Obstetric engagements once accepted should be faithfully fulfilled, no matter how awkwardly they fit. Apply the same rule of cleanliness to rich and poor alike. Decline service when this cannot be done. Human life is too precious to jeopardize it by slipshod, half-hearted, or indifferent service.
2. The physician should be a model of cleanliness in body and clothing, and should insist upon the observance of similar conditions by all persons in and about the lying-in chamber.
3. The delivery room, whether in hovel or palace, court, alley or avenue, should be simple in its furniture and hangings, and be cleaned with soap, water, and whitewash (if possible to use the latter) immediately before occupancy by the puerpera.
4. The delivery bed should consist of a new tick filled with sweet and clean straw, covered with a blanket, impervious dressing and a folded sheet, with other clean covering to be allowed, according to season. Exceptions to this simple bed should be as few as possible, and in no event should a bed be substituted that has been used by the sick, or that is not beyond even a suspicion of infection.
5. The patient should be specially prepared for delivery by baths and enemata, vaginal douches, and clean clothing; and labor should be conducted on the lines of absolute cleanliness, with few digital examinations, and a complete delivery of the secundines.
6. Lesions of the genital tract should receive careful attention; rents of the perineum should be repaired, and so, too, in some instances should tears of the cervix.
7. Antiseptic solutions containing a germicide should be used for cleaning the hands and instruments of the operator. Intrauterine irrigation with sterilized water should be carefully employed after operative midwifery, either manual or instrumental.
8. Finally, if sepsis proceed to suppuration and abscess, the abdomen should be opened, pus cavities emptied, irrigation used, and drainage established. If the uterus and adnexa become thoroughly infected, they should be extirpated.

THE USE OF CHLOROFORM IN MIDWIFERY.—It would be interesting to learn what proportion of normal labor cases in this country are facilitated, and the pangs of the acme of the second stage mitigated, by the use of a small quantity of chloroform. It is safe to say that whether the practitioner has been taught in his student days to use it, or has been instructed on that other line, which has fully developed in it all the merits and demerits of conservatism, that nature is the best midwife, and should be left to take her course, he will not use it more than once or twice in practice without being converted to its use in every case, normal or other, in which it is not specially contraindicated. The safety of the procedure depends, as is now well known, upon two points; first, that the pain at the end of the second stage is sufficiently controlled by far less anæsthesia than would be necessary for surgical purposes, less too than would be needed to stop either uterine contractions or even the contractions of the abdominal muscles. The second is that the intra-abdominal pressure, before evacuation of the uterus has occurred, is too great to make it possible for the patient to inhale too much.

As to the *modus operandi;* an assistant, other than the nurse, is not needed, as the accoucheur can superintend the first inhalation, and then let the nurse give, under his direction, after, whiffs if necessary, while he is engaged at the delivery of the head. Vomiting is not apt to follow the use of the small quantity needed. If the accoucheur choose, he may give the woman a cup or tumbler, with some absorbent cotton in it upon which he has poured a little chloroform or A. C. E. mixture, and she can use it as each pain comes on, unconsciousness causing the falling away of the cup when enough has been inhaled. The main objection to its use has been the fear of increasing the liability to *post-partum* hemorrhage. If used for any purpose after evacuation of the uterus, that fear is well founded, from the risk incurred of uterine relaxation. But that need not be feared if the chloroform is used only during the second stage.

A paper read this year by Byers, of Belfast, before the Section of Obstetrics, at the sixteenth annual meeting of the British Medical Association, favors the much more frequent use of chloroform in normal labor. The author of the paper points out the fallacy in arguing that because chloroform is given and hemorrhage follows, the one is the cause and the other the effect; the old *post hoc, ergo propter hoc.* "Dr. Byers argued that the great majority of cases of alleged flooding after delivery, occurring when the anæsthetic was used, can be explained as being due, *not* to the chloroform, but either to rapid delivery or to a want of proper management of the third stage of labor, or to a combination of both these causes." The paper ended with the positive statement, as the result of a large experience, that "if proper care be used *post-partum* hemorrhage will not occur more frequently when chloroform is used than when the anæsthetic is not given."—*Editor Canad. Lancet.*

HOW TO ASCERTAIN A TWIN PREGNANCY.—It is best done by abdominal palpation and auscultation.

In twin conception, on uncovering the women's abdomen, one can at once notice the considerable dimensions of the uterus, the irregularity of its shape, a depression, even a sulcus, crossing obliquely the abdominal walls.

This sulcus is always present when the two fœtuses ses are lying obliquely one above the other, as generally happens. But it does not exist when the fœtuses are one in front of the other.

By abdominal palpation, the diagnosis is easy in the first instance, but difficult in the other instance.

At any rate, palpation at once reveals the great volume of the uterus and its irregular shape. But its tension on account of a greater amount of amniotic fluid, renders the diagnosis more difficult, as the fœtal parts are not so well defined.

By palpation it can be ascertained that in twin pregnancy the large fœtal tumors are double; for instance, one can be found near the superior strait, the other at the fundus of the uterus; and one back in an oblique and inferior direction.

In other instances, there may be found two breeches, two backs, and only one head in one of the iliac fossæ; the other head, being concealed in the excavation, can be found by the vaginal touch only. This is a very delicate point in obstetric diagnosis.

Auscultation will generally much assist in ascertaining the beat of two hearts at different points.

Charpentier justly remarks that, however, in case of rickets, with a marked narrowness of the transverse diameter, the conjugate remaining normal, the uterus is developed almost entirely above the superior straits, and consequently the volume ofthe abdomen will always indicate a pregnancy more advanced than it really is.—*Boisliniere in Am. Gyn. Journal.*

GONORRHŒA IN WOMEN.—Dr. Fred Byron Robinson, in the *Medical Age,* sums up the treatment of this disease as follows:

1. Gonorrhœa may be cured if it be taken early enough so that the germs are not beyond control of local application.

2. The microbes must be radical germicides applied directly to the habitat of the gonococcus.

3. When gonorrhœa gets into the fallopian tubes, it is an incurable disease except by extirpation of the appendages.

4. Probably the best internal remedy in gonorrhœ is the balsam of copaiba. The urine secreted while taking copaiba seems to act on the gonococcus and cripple its multiplication.

For a local remedy, $AgNo_3$ solution of 10 per cent is probably one of the most effective, while at the same time it is not destructive to surrounding tissue.

A DISLOCATION OF BOTH KNEES FORWARD DURING INTRAUTERINE LIFE.—This case fell into my hands Feb. 24, 1893. The parents are mulattoes; this was Mrs. L.'s seventh confinement; and her first child, if still living, would be now in his tenth year. I was not present when this child was born—the attendant was only a "woman;" but the mother is intelligent, and her account of the labor is as follows:

This child was born doubled up, by a presentation of the head and feet together. The thighs were flexed upon the body as usual, but the legs were unnaturally extended, with the toes pointing backward. I ascertained by careful inquiry that there was an abnormal deficiency of the liquor amnii; and in geting at the cause of these luxations, this fact, probably, affords the guiding idea. At some point in the gestation she extended the legs upon the thighs, as any vigorous child may do, and was never afterward able to flex them again for want of room; and con-

sequently, the knees thus extended were gradually bent *backward* and pressed out of joint by being forced to conform to the sharp curves of a very small uterus. The legs, when the thighs were extended, stood forward at an obtuse angle of more than 165°; and, as far as voluntary motion was concerned, were immovably fixed.

Thus it appears that these dislocations were chronic. No inflammation or soreness, or appearance of extravasated blood resulted, either from the labor or from the reduction of the dislocations six hours afterward. The reductions were neither difficult nor painful, and the knees afterward appeared to be all right. There was left, however a tendency to a spontaneous recurrence of the displacements. This was counteracted by applying a bandage to each foot and extending a free end back to the diaper, long enough to give the leg freedom of motion, without permitting it to become fully extended. At the same time the nurses were instructed to practice passive motion of these joints as often as the diapers were changed, taking care not to let the legs become more than fully extended. A natural recuperation will do the rest.—*Kinne, in Am. Gyn. Journal.*

Longings of Pregnancy.—Giles has investigated 300 cases of what he terms "natural" longings. They are vastly more frequent in married primiparæ, and much less so in unmarried girls and in multiparæ. In many cases they are to be attributed to the popular belief that they are to be expected. Some are manifestations of disordered nervous condition, while others are instinctive cravings for substances needed by the mother or her child.—*Med. Press.—Times and Register.*

Ante and Post Partum Douches.—In a discussion of this subject before the Philadelphia County Medical Society, *Times and Register*, Dr. Joseph Price said:

During the last six years I have kept a record of the number of puerperal deaths occurring in my consulting practice. I have seen over one hundred such cases. I cannot sufficiently emphasize my position in this matter, for I see too many women dying to hesitate to express myself freely. I have been interested in some eight thousand cases of labor, and I have had nearly thirteen hundred lying-in patients at the Preston Retreat without a death from *any cause.* The practice at the retreat has been that of the greatest cleanliness possible to obtain, from the admission to the discharge of the patient. I always regard a woman after labor as a wounded patient and treat her as such. Sometimes the wounds are deep and severe, and without proper antiseptic precautions many of these women would die after childbirth. When I find a woman after labor, dying with high temperature, I generally find a severe lesion of the perineum, vagina or cervix.

I agree with what has been said in regard to the importance of the ante-partum and the post-partum douche. I look upon creolin as absolutely worthless and carbolic acid as quite as useless. I value the ante-partum douche quite as much for the saving of the infant's eyes as for saving the life of the mother. I firmly believe that if every woman delivered in this State in the next ten years had an ante-partum mercurial douche carefully administered, the number of blind asylums would be reduced from five to one. In the thirteen hundred women admitted to the Retreat there were three ophthalmias. One was delivered in the gutter, another in the hallway and the third in the bath-room, all before a bath or a douche. These were the only three ophthalmias born within the institution. There has not been any other cases in the Retreat for two years. I employ as the solution corrosive sublimate 1 : 2000.

Danger of Vaginal Pessaries.—Dr. Neugebauer, of Warsaw, has published an exhaustive analytical monograph on this question, so important in these days when gynecology is widely practiced by the surgeon and physician as well as the specialist. Two hundred and forty-two cases of injury have been collected and analyzed, five more being added in an appendix. Tabulating the results, Dr. Neugebauer presents the medical public with the following formidable statistical records: Twenty-three cases of perforation of the rectum alone by the pessary; twenty cases of perforation of the bladder alone; ten cases of perforation of the bladder and rectum; one case of ureteric fistula alone; one case of ureteric and vesico-vaginal fistula alone; one case of urethral-vaginal fistula; two cases of perforation of the Douglas' pouch (neither fatal); three cases of perforation of the vaginal walls, the extruded portion of the pessary lying in the pelvic connective tissue; and six cases of entry or a vaginal pessary into the uterus.

As to the age, one patient was ninety years old; she had worn a wooden pessary for forty-five years. The youngest was nineteen. The time during which the pessary was worn (and often forgotten) is tabulated, the nonagenarian just mentioned heading the list; two other women wore their pessaries for forty years; and twenty, besides these three, wore the instrument over twenty years. The toleration of the vagina is very varied in different individuals, even for the same kind of pessary; thus in some cases the pessary became fixed, and tended to ulcerate into the vaginal wall within two or three months, whilst in others the appliance was worn over twenty-years without causing any objective or subjective troubles. How fetor could have been absent in these tolerant cases it is hard to understand. We must remember that the same kind of pessary is not always introduced with the same skill, whilst other pessaries may be bad in principle or ill-made by the manufacturer, and, lastly, the patient very frequently forgets that she wears a pessary, hence the share of blame which the introducer of the instrument should bear is not uniform.

When the patient is not aware that the instrument has been inserted, as is often the case, the medical attendant must undoubtedly have shown great skill and gentleness in introducing it, but he may not have taken sufficient pains to impress upon her memory the fact that the instrument has been introduced and must not be worn for many months. This is the commonest cause of pessary accidents at the present time, for the art of introducing pessaries is readily acquired, experience is easily obtained, and the favorite pessaries are no longer barbarous instruments, whilst the patient may misunderstand such information as "I have passed a Hodge," or "You are wearing a Zwanck," and go away with the belief that she is *not* wearing a pessary. As to the merits and disadvan-

tages of the almost innumerable forms of pessary, we must refer the reader to Dr. Neugebauer's valuable paper. The moral is that the introduction of a vaginal pessary is a minor surgical proceeding, but if performed carelessly may lead to results in no sense "minor," but, on the contrary, very serious.—*British Medical Journal.—Med. and Surg. Jour.*

Opthalmology.

A Combination of Alkaloids in Ophthalmology.—M. Berger declares that by combining alkaloids we may obtain the same effects with smaller doses. As a mydriatic he advises :

℞ Atropine sulphate,
Duboisine sulphate.....āā gr. ivss.
Cocaine hydrobromate..... gr. xxx.
Distilled water..... f ʒiij.—M.

As a myotic he recommends :

℞ Eserine sulphate..... gr. xv.
Pilocarpin hydrobromate..... gr. xxx.
Distilled water..... f ʒiij.—M.

A mixture of

℞ Cocaine hydrochlorate,
Polocarpin hydrochlorate.....āā gr. xxx.;
Distilled water..... f ʒiij ;

gives all the qualities of the cocaine with the further advantage that the difficulties of mydriasis and effect upon accommodation observed in the eye when cocaine alone is used do not exist.—*Therap. Gazette.*

Granular Lids.—Dr. G. Sterling Ryerson orders, applied at night

℞ Hydrarg. oxid. flav..... gr. iv.
Zinci oxid..... gr. ij.
Thymol..... ♏ij.
Camphor..... gr. ss.
Cocain. muriat..... gr. ij.
Vaselin..... ʒj.—M.

—*Therap. Gazette.*

The Disease Process Glaucoma.—Usually glaucoma is looked upon as a mysterious disease for whose origin there is no known cause, and for whose relief an iridectomy is the only resource. Unfortunately the iridectomy is by no means a certain relief in all csses, and then blindness more or less complete is the result.

In a recent paper in the *American Journal of the Medical Sciences,* Dr. Richey elaborates a view which he had previously announced, to the effect that the morbid process of glaucoma is a hyperplasia of connective tissue which diffuses itself through the whole organ, possessing the property of pathological connective tissue to always contract. Hence he regards the initial lesion of glaucoma disease as a connective-tissue proliferation, with the inevitable consequence of contraction, and so interference with all the higher functions of the eye.

This proliferation of connective tissue he thinks arises from the excess of uric acid in the blood and tissues. Carried by the blood to the eye, the uric acid, by persistent irritation, causes an acute inflammation in the sclerotic. Hence the explanation of the fact that the sclerotic is felt to be distinctly hardened before there is any other evidence of the presence of glaucoma. This obstruction of circulation is followed by increased blood-tension, and this increased blood tension by increased connective-tissue proliferation. If the action be intense, or if the urate of soda be formed in this region, the vascular apparatus is chiefly affected, and violent inflammatory action results. In this consists the difference between chronic and acute glaucoma. The explanation of every symptom of glaucoma is quite clear if the foregoing premises are accepted. By hyperplasia of the connective tissue we can understand the impaired accommodation, premature presbyopia, increasing hypermetropia, halo, fogginess of vision, heaviness of the brow; then increased intraocular tension, circumorbital pain, peri-corneal injection, protrusion of the globe, sluggish, dilated iris, anæsthetic cornea, lachrymation, photophobia; excavation of the disc, obstruction of the channels of filtration, the white ring of the papilla; the complications of coloboma iridis, total aniridia, nephritic retinitis, detached retina, high degrees of staphyloma posticum.

The constitutional causes are due to the constitutional cause of the interstitial process.

In the fulminating form, the irritation has been sudden and violent, possibly from urate of soda. In the hemorrhagic form the walls of the blood-vessels have become first affected and brittle. In the chronic form, the irritant has been mildly persistent with periodic accessions of intensity.

In management, from a medical point of view, the indication is to prevent the excess of uric acid in the blood. Surgically, iridectomy is our only resource. *American Lancet.*

Otology.

Vaseline in Certain Affections of the Middle Ear.—Dr. Delstanche (*Le Bulletin Medical,* No. 8, 1893) speaks highly of injections of liquid vaseline in adhesive affections of the ear. He injects it through the Eustachian tube into the tympanic cavity. It is perfectly innocuous, and from an experience extending over several years he finds it of value:

1. To rupture extensive adhesions of the tympanic membrane with the wall of the labyrinth where insufflation of air, etc., are found insufficient. He has had several cases of partial success with forced injections of the liquid vaseline.

2. To clear out mucous accumulations from the tympanum during the course of certain chronic catarrhs. It forces the mucous into the mastoid cells, where it no longer interferes with hearing, or into the pharynx.

3. To diminish the chances of inflammatory reaction after paracentesis of the tympanum, where the matter filling the tympanum is dense or viscid, and will not evacuate itself spontaneously in a satisfactory manner. Here, from its innocuity, it is to be preferred to any other liquid.

4. To open an obstructed Eustachian tube when mucous blocks it and prevents insufflation of air, a few drops of vaseline blown through the catheter will clear it at once. Hence this simple means is always to be tried before dilatation with sounds is attempted.

4. Finally, in acute inflammation of the middle ear, either with or without perforation, especially in purulent otitis complicating influenza, massive injections of liquid vaseline, saturated with iodoform, render signal service, from their sedative action upon the atrocious pains which often accompany this affection. They also appear to hasten and aid to a favorable termination.—*Lancet-Clinic.*

Toxicology.

DEATHS UNDER ANÆSTHETICS.—A fatality occurred on June 7th at the Hospital for Consumption, Brompton, the record of which offers many points of interest. The observations carefully made at the time have, through the courtesy of the resident staff, been placed at our disposal. The patient, a painter aged thirty-five, was admitted to the hospital on June 5th and was then suffering from an empyema on the left side, which communicated with the bronchi of the left lung, occasioning cough and the expectoration of pus. The condition rendered an operation imperative, and on the 7th it was determined to resect a rib and evacuate and drain the pleural cavity. The man's state was deemed very grave. He had been ill for ten weeks and the quantity of pus thrown from the chest rendered the use of an anæsthetic a matter of extreme danger and difficulty. The chloroform (Duncan and Flockhart's) was given from a single layer of lint by a skillful and experienced medical officer, who possesses special knowledge of these cases, and who throughout gave earnest and undivided attention to his responsible task. As a preliminary the patient, who had been carefully prepared for the anæsthetic, was induced to sit up and expectorate all he could from his lungs. The chloroorm was then administered, being dropped from a drop bottle upon the lint, and the respiration constantly watched. The patient took the chloroform well; there was a little excitement and struggling, but this soon passed off. The color, however, became somewhat dusky, although the respirations remained full and deep, and this fact made the chloroformist request the operator to be prepared, if need be, to incise the thoracic parietes at once. A brief period of muscular rigidity ensued, but the full or third (Snow) stage of chloroformisation was only attained for a few seconds. The operation was begun six minutes from the commencement of inhalation and in about one minute after this, as the rib which was exposed by the surgeon was being denuded of its periosteum, the patient's color became darker and his respiration impaired, whilst his pupils dilated. The chloroform was withdrawn and the tongue pulled forward, but in spite of this the respiration became irregular and in about half a minute stopped. During the struggling stage some pus had been coughed up and there seemed to be still some in the trachea. An opening was at once made into the thorax and sixty to seventy ounces of pus were evacuated, but without any amelioration of the patient's symptoms. Artificial respiration was then carried out, and after a few minutes breathing was restored and the radial puse became again perceptible, whilst the color greatly improved. Artificial respiration was then discontinued and the patient took about ten deep natural breaths, when the respiration quietly failed and the radial pulse grew imperceptible. Resort was again had to artificial respiration; the feet were elevated and the head lowered, ether being given hypodermically. The tongue was kept forward throughout. These resuscitative measures were presevered in for twenty minutes, but no sign of revival was obtained. In all, about three drachms of chloroform were employed. A necropsy was made and it was found that the bronchi of the right lung were full of pus, even those of the upper lobe. The lung, except for œdema, appeared normal, but the left lung was completely collapsed. The heart was dilated and flabby. The reporter further adds that he believes that the respiration failed before the heart's action ceased and that the symptoms described and the post-mortem appearances recorded leave little doubt on the mind that such must have been the case.

These terrible complications under chloroform are of peculiar moment. The mechanism of death is clearly asphyxial from invasion of the sound lung by the pus from epyema, and the sedative effect of the anæsthetic by abolishing coughing reflex aggravated the grave condition of the patient. Chloroform in these cases is certainly the safest anæsthetic when the narcosis is not allowed to pass beyond the first or second stage, and even then, as in the above case, no amount of care will ward off peril. Probably the anæsthesia of the period before loss of reflex excitability is not sufficiently studied or practiced. The next case we have to report is one of death from chloroform which occurred at the New Hospital for Women, and we are indebted to the authorities of that hospital for placing the notes at our disposal. A married woman aged forty-three was admitted for operation to relieve dyspnœa and dysphagia arising from the presence of goiter. On Saturday, June 17th, the patient was carefully examined by the anæsthetist to the institution and found, in her opinion, to be capable of taking chloroform, which was accordingly given on folded lint. The induction of anæsthesia was normal, except that no struggling occurred, and took about seven or eight minutes. The operation was in progress, when some temporary respiratory irregularity occurred as the thyroid was dragged upon, but disappeared as soon as the dragging ceased. The pulse was unaffected. Two or three minutes later the breathing "faltered," grew rapid and deep, and then stopped, and the pupils dilated widely. The operation was suspended, the patient was dragged to the end of the table, the head hanging back, the tongue was drawn forward and artificial respiration maintained for three-quarters of an hour. Air entered the chest freely at this time. As subsidiary measures of resuscitation aromatic spirit of ammonia and ether were injected under the skin, brandy enemata were thrown into the bowel, the legs were raised, the præcordium was excited by a faradic current, the heart was kneaded from the diaphragm with the hand and the chest was rubbed and slapped with a wet towel, but no attempt at revival took place. A necropsy was not allowed. In all operations involving the neighborhood of the distribution of the vagus aud nerves closely associated with it there is a tendency to reflex excitation of the respiratory center, and the onset of rapid breathing so induced is a danger signal indicating that no more chloroform should be given until the rhythm is restored. Even when this precaution is followed there is a danger lest the rapidity with which the chloroform actually in the air-passages is carried into the circulation may produce an overdose. These two cases emphasize the extreme importance of watching the respiration.—*Lancet.*

Dermatology.

OHMANN-DUMESNIL ON PARASITES OF THE SKIN; TREATMENT.—1. *Scabies.*—A method which I have successfully employed, is this: The patient takes a hot bath with some alkaline soap, in the morning, putting on a complete change of clothes. He then

applies in the interval, *i. e.*, before assuming the change of clothing, and after thoroughly drying the skin, the following:

℞ Sodii hyphosulphit.....℥ viij.
Aquæ destillat.....℥ viij.
M

After being applied it is permitted to dry on the skin, then the clothing is put on.

In the evening before retiring the following is applied:

℞ Acid hydrochlorici dil.....℥ vj.
Aquæ destillat.....℥ iv.
M.

If it be too severe, the acid may be further diluted so as not to prove too painful.

The effect of this treatment is marked, and it possesses several advantages over other methods. It is cleanly in the first place. It is easy of application, and it ensures a precipitation of sulphur in an exceedingly divided state in every small fissure which may exist, thus making it as thorough as it is possible to do so. The process should be repeated daily for three or four days, not omitting the change of underwear and clothing. The clothes temporarily cast off should be subjected to a dry heat sufficiently intense to kill any lurking parasites, and yet not so high as to scorch the material.

2. *Head Lice.*—I have found one of the best remedies to employ for this purpose is campho-phenique, which not only kills the parasite and destroys the ova rapidly, but has the further effect of acting as a vulnerary on the secondary lesions which have been caused by scratching. It may be used two or three times daily on the dry scalp. In the case of females with long hair, we have a more complicated condition of affairs to deal with. The hairs are frequently full of ova, and these must be eliminated *pari passu* with the destruction of the pediculi. For this purpose a thorough shampoo with sapo viridis is unexcelled, as it dissolves the nits and cleanses the hair. When the hair and the scalp have been thoroughly dried, the same remedy as mentioned above may be used.

3. *Body Lice.*—Same as for head lice.

4. *Pediculosis Genitalis.*—Lotions are certainly more desirable, but thoroughness should be observed in their use, not only for each application but for the length of time they are applied. They should be used twice a day for not less than eight days, as this will insure the destruction of whatever parasites which may have been hatched out during this interval and will furthermore prevent the breeding of a new generation. An easily procurable lotion is a six per cent aqueous lotion of carbolic acid. One which is of value when no excoriations exist is composed as follows:

℞ Hydrag. bichlorid.....gr. iv.
Aceti aromatic.....℥ vj.
M.

When excoriations or other secondary lesions exist however, it has been my custom to employ campho-phenique, as it is not only an efficient parasiticide, but it also acts beneficially as an antiseptic.

5. *Flea Bites.*—The treatment of flea bites is perhaps not so important as the adoption of prophylactic measures. For the former a number of adequate applications may be used, and one of the best perhaps is an aqueous solution of some antipruritic such as the following:

℞ Hydraggyri bichloridi.....gr. ij.
Ammon Muriat.....gr. iv.
Acid. carbolici..... ℥ ij.
Glycerini..... .....℥ ij.
Aquæ rosæ.....q. s. ad. ℥ vj.

This should be applied several times in the day, and a quick recovery will result. But it will scarcely prove efficient unless the skin is freed from the little pest which causes the trouble. To accomplish this clothing should be carefully removed and exposed to the air, and a carefulness exercised that the fleas will not leap into other articles of clothing.

Bedbug Bites.—The treatment for the cutaneous trouble caused by the cimex, is usually a simple one so far as allaying the symptoms is concerned. Dilute alkalies, vinegar, alcohol, whisky, etc., are the more commonly recognized domestic remedies. It is best, however, to use a dilute solution of bichloride of mercury, as it will not only cause the disappearance of the symptoms, but will act as an antiseptic, and prevent any possible phlegmonous complications. Campho-phenique will do the same thing, and possesses an added advantage in being an anæsthetic.—*St. Louis Med. and Surg. Jour.—Epitome.*

MISCELLANEOUS.

BREATHING EXERCISES.—Breathing exercises are of great value, most easily practiced, and give excellent results. It is not necessary to have an elaborate system. The nostrils are the proper organs of breathing. Man, unlike some other animals, is capable of breathing through the mouth if the nostrils are obstructed, and many from habit or debility continually do so—a practice, whether by day or by night, attended with many evils; whereas every breath of pure air a man inhales through his nostrils is a breath of life.

One exercise, repeated fifty or a hundred times a day, requiring no more than ten minutes altogether, is of the greatest advantage and can be done out of doors as well as in, at almost every season of the year. It consists in inhaling through the nostrils a deep breath, retaining it a few seconds, and then, with the lips adjusted as if one intended to whistle, expelling it slowly through the contracted orifice. There is no physiological objection to exhaling through the mouth; there are no muscles whereby the course of the breath can be restrained through the nostrils; but the lips contain sufficient muscular strength for this purpose. If students would rise from their studies, bookkeepers from their desks, women from their sewing or reading, two or three times a day and take from fifteen to thirty such breaths, the results would surprise them.—*The Chautauquan.*

THE EFFECTS OF SOME ANTISEPTIC SOLUTIONS ON THE COMMA BACILLUS.—The author has studied the effects of the following solutions on Koch's bacillus:

1. Corrosive sublimate, 1 in 1,000.
2. A mixture of 1 pint of sulphuric acid and three parts carbolic acid, of the strength of 6 in 100 of water.
3. A mixture of quick lime and water, 20 in 100.
4. A solution of carbolic acid, 5 in 100.

The following procedure was used:

He put equal parts of the antiseptic solution and choleraic dejections that contained the bacilli into a

test tube. After a certain exposure he took samples to make gelatine plate cultures, with the following results :

1. The corrosive sublimate, unless it came in contact directly with the microbe, had a very slight germicidal power.

2. The lime mixture killed them in the majority of cases; but the mixture had to be well stirred up with the dejections.

3. The mixture of sulphuric acid and carbolic acid, as also the carbolic acid solution, always killed the bacilli, and this without having to shake up the mixture.—*Bul. Gén. de Thérapeu.—Canad. Pract.*

HEALTH COMMANDMENTS.—1. Thou shalt have no other food than at meal time.

2. Thou shalt not make unto thee any pies or put into the pastry the likeness of anything that is in the heavens above or in the earth below. Thou shalt not fail to chew it or digest it, for the dyspepsia shall be visited upon the children to the third generation of them that eat pie, and long life and vigor upon those that live prudently and keep the laws of health.

3. Remember thy bread to bake it well; for he will not be kept sound that eateth his bread as dough.

4. Thou shalt not indulge sorrow or borrrow anxiety in vain.

5. Six days shalt thou wash and keep thyself clean and the seventh day thou shalt take a great bath, thou and thy son, thy daughter, and thy maid servant, and the stranger that is within thy gates. For in six days man sweats and gathers filth and bacteria enough for disease; whereupon the Lord has blessed the bathtub and hallowed it.

6. Remember thy sitting-room and bed chamber, to keep them well ventilated, and thy days may be long in the land.

7. Thou shalt not eat hot biscuit.

8. Thou shalt not eat thy meat fried.

9. Thou shalt not swallow thy food unchewed, or highly spiced, or just before hard work or just after it.

10. Thou shalt not keep late hours in thy neighbor's house nor with thy neighbor's wife, nor man servant, nor his maid servant, nor his cards, nor his glass, nor with anything that is thy neighbors.—*Med. Brief.*

EARLY ADMINISTRATION OF ANÆSTHETICS.—In a letter to the *Medical and Surgical Reporter*, Dr. Geo. Foy makes the following interesting statements :

Sir James Simpson, in 1847, was the first to use chloroform. I do not propose to open the question as to the discovery of modern anæsthesia. I have already treated of the subject in my book, "Anæsthesia: Ancient and Modern," which had the honor of being reviewed in your journal of April 29, 1890. But I may draw your attention to the fact that, as I mention in my book, Dr. Long, of Jefferson, Ga., in March, 1842, etherized a patient from whom he painlessly removed a tumor. A very full and interesting account of this operation was published in the *Virginia Medical Monthly* for May, 1877, by Dr. J. Marion Sims, who had the account from Wilhite, of Anderson, S. C., who was an apprentice of Dr. Long, and was present at the operation.

In 1831, Prof. Ives, of New Haven, used to dilute chloroform—chloricether—as an anæsthetic, and his case is reported in *Silliam's Journal* for January, 1832.

How ether came to be used by inhalation for the relief of pain, is told in an old and rare copy of *Beddoe's Journal* which, if time permits, I may some day publish.

BUNGHOLE STRETCHING.—The editor of the *Eclectic Medical Journal* is a gentleman of pronounced opinions as the following editorial from his journal will attest :

This may not be the technical name of the operation, but it will serve our purpose to point a moral to "orificial surgery gone mad." We have noticed for some time that "anal stretching" was becoming a feature of the new surgery, and that "anal dilators" were becoming instruments to which men were attaching their names as inventors, and attributing wonderful results as "stimulators of the capillary circulation" and the sympathetic.

But this thing goes by leaps and bounds; it does not walk and feel its way as does ordinary medicine. A recent case of anal dilatation in Cook County Hospital will illustrate :

"An operation was to be performed on a woman, and a number of physicians were invited to witness the surgical skill. The patient was being put under the anæsthetic; indeed, was put under it too far, and 'let go.' At once all was excitement, and efforts were made in sundry directions toward resuscitation. They seemed of no avail, and the woman was dying or dead. One of the visitors who had just attended his course on 'orificial surgery' with Dr. Pratt was very much interested, and asked : Have you heard of 'anal dilatation' in such cases? They had not. May I be permitted to take charge? He was permitted, and rushed forward, inserted both thumbs in her anus, and with herculean strength divulsed the sphincter. She gasped, she breathed, the rosy flushed her cheeks and lips; she was saved."

I may not have given the story in the flowery language of our homæopathic exchange, but I have given the facts as reported. If Cook County denies it, then I shall believe that Cook County wants to cover up their want of skill in the use of anæsthetics, or their lapse from virtue in allowing a believer in "orificial" to save a human life.

You can see how it is yourself. If one had a straight ticket for the other world, and suddenly some one should thrust both thumbs in his anus, and rend it, he would come back to see what was the matter. It stands to reason, and does not require an argument, especially if the person should be a woman.

Divulsion of the sphincter is a good thing in some cases, as removal of causes of irritation of the orifices of the body is a good thing. But it does not want to be vaunted too much. As I read it, a line from Shakespeare is brought forcibly to mind: "Methinks this women doth protest too much."

A CLINICAL HISTORY.—A contemporary prints the following : Elderly spinster to doctor, who has been asked to call between eleven and a quarter past, at a distance of many miles from his house : "I thought, Dr. Corax, that perhaps I might as well see you, as I fancy I have got a cold, and I think I had better tell you how I caught it. It was last Friday—or was it Thursday? What was the day when it rained so in the afternoon and evening? You don't remember? I think it was Friday, because the *Weekly News* always comes on Friday evening, and I half remem-

ber that when I came in the paper was lying on the hall table. I wanted to post a letter to my sister who lives in Dorsetshire, to tell her how very sorry I was to hear of the loss of so many of her best poultry—a fox had got at them, and made sad havoc in the poultry yard—but that is neither here nor there—and Sarah being out, I slipped on my cloak and ran across to the post office. But the ground was very wet after all the rain that had fallen that afternoon, and not being able to find my goloshes—" Doctor, breaking in: "Exactly. You got your feet wet—a most common cause of a cold. I shall be able——" Patient: "Please hear me out. As I could not find my goloshes, I put on a pair of thick felt boots, which could not have let any water in, so I am sure it did not arise from my getting my feet wet. But just as I got to the post office door a gust of wind blew my bonnet off." Doctor: "A perfectly clear statement. I will now——" Patient: "Will you allow me to explain myself? After all I do not believe that I got the chill in this way. Over and over again I have told Sarah by no means to allow the passage window to be open on cold or wet nights. Only a few days ago I said to her: 'Sarah, you may be used to it, but I am not. In this house my will is law. I desire you to pay attention to what I have said about the passage window.' 'Yes, ma'am,' says Sarah, as uppish as you please; but——" Doctor (who has got his thermometer ready): "Ah, yes; exactly. Allow me to place my thermometer under the tongue; and will you kindly keep the mouth closed for the three minutes that are necessary for ascertaining your precise temperature. I will prescribe at once." During the three minutes the prescription is written, the doctor puts on his gloves, gathers up his hat and umbrella, and notes that there are no obstacles in the way of escape. All being prepared, he ejaculates emphatically: "Thank you. A normal temperature, I see. Good morning. You will find yourself quite well to-morrow taking what I have prescribed," and vanishes.—*Canad. Lancet.*

The Justifiable Prevention of Conception.—The physician not infrequently has to warn against conception in cases where a pregnancy would endanger the life or the health of the patient. Pelvic contraction, abdominal and uterine tumors, etc., form such an indication. The advice to abstain from coitus is but seldom followed, and the means usually employed to prevent gestation (mechanical) are objectionable from a hygienic and ethical point of view. Kleinwächter has endeavored to find a remedy which would have none of the aforementioned drawbacks. He prescribes a cacao-butter suppository containing 10 per cent of boracic acid, to be introduced high up into the vagina. These suppositories dissolve in about one hour, and the liberated acid destroys the spermatozoa. Bichloride of mercury in 0.001-gramme doses can also be used, but in that case a vaginal douche has to follow the sexual act. The solvency of the suppository is heightened by adding one grain of oleum olivæ. The author considers this a safe and sure remedy to prevent conception. Therapeutic effects may be combined by the adding of various drugs—for instance, tannin in cases of uterine catarrh. —*Med. Age.*

Reform in Spelling.—Dr. George M. Gould concluded an address on this subject to the association of medical editors, *American Lancet*, with the following:

There is not a single argument of value against a moderate and at least a small beginning of some kind for spelling reform of our intolerable English orthography. As regards the spelling of medical words, any argument has less weight than as regards other words. We owe it to our profession to be professive to be progressive in this respect, or at least not to be a dead weight to the car of progress, and at the very least not to pull backward like an over-obstinate horse when the wagon (with one g) is pushed on to our heels. Wherefore brethren, will you not assent to the little advance already gained? And will you not assent to a few little, timid steps further? Every argument of logic and of uniformity, and every motive of good will and interest in progress is on this side. Why shall we not drop the combined letter, diphthongs in all words? Let us drop the *æ* in words derived from Greek, and write *e*; for instance, hemorrhage, hemostatic, etc. The same with all other original Greek, *æ*'s, usually spelled *æ* as an orthopædic, pædiatrics; anæsthetic. The same with *œ*. Let us accept edema, celiotomy, diarrhea, fetus, etc. Let us adopt with never a wry mouth the American spelling of honor, center, meter, program, traveler, and the rest. Let us get a chart of the rules for spelling chemic terms adopted by the American Association for the Advancement of Science, and hang it in front of our desks, and never spell iodid, sulphid, hydrid, morphin, chlorin, etc., with more e's than we should. Let us be sensible rather than conservative.

Of all the languages of the civilized world there is none that in the most distant manner rivals the English in the ludicrous illogicality and wretched lawlessness of its orthography. In other languages there is a manifest philological sanity that evidently seeks to hold the written or printed word in some sort of relationship with the spoken word. But in our language the reverse seems to be the case: The more methods in which a single sound could be spelled, the better it seemed to please the fathers of the language. The labor which this fact imposes upon the child's mind is a labor that, conceived in its entirety, is literally appalling. The German child learns in one year, and well, what the English child learns in three, and poorly.

The Treatment of Obesity by Diet.—Dr. Towers-Smith after detailing a number of cases treated by the method which he usually applies, recommends the following dietaries:

DIET FOR AN EXTREME CASE.

First period, fourteen days. Breakfast.—Tea or coffee, with saccharin, if desired, in lieu of sugar; bread or biscuits made from soya bean, two ounces; grilled white fish or red meat, kidneys. Lunch.—Cut from joint of beef or mutton, taking no fat, and one helping of green vegetables, avoiding only peas, beans, and all roots; soya bread or biscuit, one ounce. Dinner.—Clear soup, white fish, red meat, green vegetables, as at lunch; soya bread or biscuit, one ounce.

DRINK.

First thing on awakening. Tumbler of hot water with slice of lemon.

11 A. M.—Cup of bovril or clear soup.

Lunch.—Two glasses of claret or one ounce of whiskey with potash water.

5 P. M.—Cup of bovril or clear soup.

Dinner.—Two glasses of still hock or claret, or whiskey and potash. Bedtime.—Cup of bovril or clear soup. Mustard, pepper, salt, Harvey sauce may be taken. Additions to No. 1.—Oysters, tongue, stewed fruit with saccharin, poultry, game. Third period, thirty-one days. Additions to No. 2.—Toast in place of soya bread for each meal, two ounces; savory jellies, aspic of prawns, plovers' eggs, jelly. Dessert.—A small quantity of fruit; blue mould Dorset cheese. No. 1.—Specimen diet chart. This diet sheet is arranged in accordance with usual habits and family history as to obesity, and must be strictly confined to personal use. Name and address,

189 . Diet chart for fourteen days.

7 A. M.—Sip slowly a tumbler of hot water with lemon juice.

9 A. M., Breakfast.—Two cups of tea or coffee without sugar or milk, taking saccharin if needed; one ounce of soya bread or biscuit; grilled white fish, steak, chop, kidneys.

11 A. M.—Tumbler of hot bovril or clear soup.

1:30 P. M., Lunch.—Cut from joint of beef or mutton, with one helping of either cabbage, spinach, tomatoes, asparagus, French beans, plain lettuce, and water cress; one ounce of soya bread or biscuit.

5 P. M., Afternoon Tea.—Cup of tea *a la Russe*, or cup of bovril.

7:30 P. M., Dinner.—Clear soup, white fish, red meat, vegetables as at lunch; one ounce of soya bread or biscuit. Bedtime.—Tumbler of hot bovril or clear soup.

1. All food should be plainly cooked (grilled for preference); no fat, skin, or rich gravy should be taken.

2. Drink claret, still hock, burgundy, Scotch whiskey and potash water.

3. Exercise: A moderate amount of walking should be done daily.

4. Condiments: Mushroom catsup, Worcester and anchovy sauce, mustard, pepper, and salt may be taken. —*Edinburgh Medical Journal.—Jour. of Balneol.*

Announcements.

Pan-American Medical Congress.

Dr. Ernst Hart, editor of the *British Medical Journal*, and Prof. Dr. Czerny, of Heidelberg, will be among the distinguished guests of the Pan-American Medical Congress. The latter is booked for the Pan-American excusion to Rome by the "Werra."

Official Delegates to the Pan-American Medical Congress:—Practically all of the governments have appointed official delegates to the Congress in response to the invitation by the President of the United States. The United States government will be represented by six delegates. The larger cities of all the Latin-American countries have appointed delegates to participate in the proceedings of the sections on hygiene, climatology and demography and on marine hygiene and quarantine, and similar appointments will be made by the cities of the United States. Seventy-six similar delegates have so far been appointed by the Governor of States in the United States. A large number of delegates have been chosen by the medical colleges of the United States and other American countries to attend the section on medical pedagogics, under the presidency of Professor J. Collins Warren, of Boston.

Section on Materia Medica and Pharmacology —Pan American Medical Congress.

A Section on Materia Medica and Pharmacology has been organized under tne executive presidency of Prof. Joseph P. Remington, of Longport, N. J., with Prof. F. G. Ryan, 3,739 Brown St., Philadelphia as English-speaking Secretary. This section promises to be one of the most important of the entire congress. Delegates have been invited from all the pharmaceutical societies and colleges in all the Americas. Those contemplating attendance are invited to prepare papers on pharmaceutical topics. Titles should be sent at once to Prof. Ryan, Secretary.

Publisher's Department.

Neuralgia.—The editor of the *St. Louis Medical Era* finds in the treatment of this troublesome affection that "antipurolgos in five grain doses, successfully controls the pain, and places the patient in excellent condition to secure the effect of the constitutional remedies indicated." He prefers the "antipurolgos" to any of the other coal tar derivatives.

Pamphlets Received.

Cocaine Poisoning. By J. B. Mattison, M. D. Reprint from the *Medical and Surgical Reporter.*

The Etology of Narcotic Inebriety. By J. B. Mattison, M. D. Reprint from the *Weekly Medical Review.*

Cocaine Inebriety. By J. B. Mattison, M. D. Reprint from *Medical Recorder.*

Twenty-seven years addiction to Opium. Recovery. Relapse. By J. B. Mattison, M. D. Reprint from the *New England Medical Monthly.*

The Mattison Method in Morphinism. By J. B. Mattison, M. D. Reprint foh mjre *Universal Medical Journal.*

Trional, the new Hypnotic. Its use in Narcotic Habitués. By J. B. Mattison, M. D. Reprint from the *Medical News.*

Apparent and Actual Mortality. By F. D. Bullard, A. M., M. D., Los Angeles, Cal. Reprinted from *Southern California Practitioner*, June, 1893.

The Indications for Amputation in Chronic Disease of the Larger Bones and Joints, with a Report of Seventeen Recent Cases, Including Three Successful Amputations at the Hip Joint. By J. E. Summers, Jr., M. D., Omaha, Neb. Reprinted from the *Omaha Clinic*, July, 1893.

Book Reviews.

"Kirke's Handbook of Physiology. Revised by W. Morrant Baker, F. R. C. S., and Vincent Donner Harris, M. D., London, F. R. C. P. Philadelphia: P. Blackiston, Son & Co. 1892. 862 pages. Cloth, $4.50.

This work on Physiology having passed its thirteenth edition, needs no words to recommend it to the profession. An account of Physiology has been brought up as far as possible to the present time, and the whole book undergone a very thorough revision, the scope of the work being somewhat enlarged. The cuts are unusually good, especially the tinted ones. Although this work is essentially intended for students, the practitioner will find it one of the best from which to refresh his memory.

"A Handbook of the Diseases of the Eyes and their Treatment." By H. R. Swanzy, A. M., M. B., F. R. C. S. I. Fourth edition with illustrations. Philadelphia: P. Blackiston, Son & Co. 1892. Price, $3.00.

This valuable work alike to students and practitioners, has reached its fourth edition, each being issued with remarkable rapidity soon after its predecessor. This speaks for the favor with which it has been received by the profession. The book has now again been revised throughout, and brought up to date. In an appendix, Holmgren's method for testing the color sense has been described in greater detail than before, and more new illustrations added to the volume. The author gives a concise and practical account of his subject in its most modern aspect, without weighting his pages with excessive detail and prolonged discussion. We would recommend this work to all for a place in the professional library as a valuable work on the eye.

"A Treatise on Hygiene and Public Health." Edited by Thomas Stevenson, M. D., F. R. C. P., and Shirley F. Murphy. Volume I. Philadelphia: P. Blackiston, Son & Co.

Some years ago the late Prof. De Chaumont proposed to the publishers of this work the issue of a treatise on Hygiene and Public Health which should contain essays by various authors, especially qualified to discuss the several subjects which come within its scope.

The editors in superintending the preparation of these volumes have been exceedingly fortunate in obtaining the coöperation of writers whose names are the best guarantee of the value of their contributions.

The subjects are in the main those which are usually selected and dealt with in similar works, but in selecting the authors it was thought well not to limit the choice to members of the medical profession. Accordingly the papers have been prepared by the most noted scientists in the different professions or departments. This work will long continue to be a standard one.

"A Handbook of Local Therapeutics." By Allen, Harte, Harlan and Van Harlingen. Edited by Harrison Allen, M. D. Octavo, 500 pages; price $4.00. P. Blakiston, Son & Co., Philadelphia.

The need for a book of this character has long been apparent, for there has been no text available in which the local action of drugs was not subordinated to their general actions, while the average text-book omits altogether mention of many agents that, in the hands of a specialist, become valuable aids to cure.

Diseases which require chiefly local treatment are those of the respiratory passages, eye, ear, and skin, together with certain general surgical affections, including diseases of women; it is therefore, to the great advantage of the work that each remedy has been thoroughly set forth by different authors who have had large practical experience in these various branches. Each remedy has been taken up in alphabetical order, and, after a description of its pharmaceutical properties, is considered in reference to its physiological effect and value in local treatment.

The demands for thorough revision of local medicaments made by the advance of theories of asepsis, have been fully considered, and a succinct account has been presented of the source and properties of the very numerous new agents which affect tissues locally.

Some drugs have been excluded which have been highly praised; on the other hand great care has been taken not to indorse imperfectly attested novelties.

This hand-book embodies the results obtained by experienced teachers, and will prove a very valuable work to the general practitioner. Two carefully made indexes make it a book of ready reference.

Items.

Twenty-three States, one Territory, and the Cherokee and Choctaw nations, are provided with medical examining boards. Ohio, the fourth State in the union, is not one of the twenty-three, but continues to be the home and asylum of quacks and charlatans.

A paste that will stick anything is said by Professor Winchell to be made as follows: Take two ounces of clear gum arabic, one and one-half ounces of fine starch, and half an ounce of white sugar. Dissolve the gum arabic in as much water as the laundress would use for the quantity of starch indicated. Mix the starch and sugar with the mucilage. Then cook the mixture in a vessel suspended in boiling water, until the starch becomes clear. The cement should be as thick as tar, and kept so. It can be kept from spoiling by the addition of camphor or a little oil of cloves—*Pacific Med. Journal.*

Wit and Humor.

In the *New York Journal of Gynæcology* Dr. Emmet tells the following of Dr. Francis, one of the old worthies in New York City. It seems that one of his patients, whom he had not suspected of being pregnant, sent for him when he was from home, so that another doctor had to be called. Greatly disturbed he came to Dr. Emmett's office and exclaimed; "Damn these hoopskirts! Young man, there was a time when I went to church that I could look around me and form some idea of what my income might be during the year. But now, since the invention of these damned hoop-skirts, I can no longer judge of the condition of the women. I am away from home when wanted, and some young whipper-snapper is called in and gets the case."

The physician replied to the telegram, saying, "I will come on the first train; in the meantime let her have apis," and the young lady operator who wired the message has refused to speak to him ever since.

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

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ORIGINAL ARTICLES.

Concerning Posture.

BYRON H. DAGGETT, M. D.

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T. Lauder Brunton contributes to the November number of the *Popular Science Monthly*, an interesting article concerning posture and its indications, in which he discusses the varying attitudes and common postures one meets with daily; illustrates these postures in schematic outline and inquiries why they are assumed.

The variable attitudes of the body are attributed to trade, habit, mutable mental states, physiological activity and pathological conditions.

Gravity in the upright posture is undoubtedly a contributing factor to engorgement of the pelvic viscera, rectal, uterine and vaginal prolapse, varicose veins, hernia, and as we grow older to sagging of the bladder and bagging of the rectum.

Our progenitors, moving about upon all fours escaped, we presume, these direful calamities and in due progress of evolution acquired the upright posture; eliminated the caudal appendage; consigned the appendix virmiformis to waste and final obliteration; will in due course reinforce venous valvular construction and develop complete support for the pelvic organs.

In the meantime we are called upon to alleviate conditions which confront and study theories which perplex.

It is proposed to consider herein some of the objective relations of this subject, so far as they concern posturing, for examination, treatment and operation.

The varying attitudes of the body, the movements of the extremities, functional activity of the internal organs and pathological conditions modify, in a greater or less degree, the environment of the viscera, which should be taken into account in examination and operation.

Posture changes the site of the impulse of the normal heart, yet the text-books scarcely make reference to it.

Paul says that the patient may sit, stand upright, or recline for examination of the heart as is most convenient.

Guttman alleges that the heart sounds are the loudest in the upright posture.

Dr. Azoulay, of Paris, claims that he has devised a means of intensifying the cardiac sounds by placing his patient upon the back, elevating the arms, flexing the lower extremities and raising the head, which reinforces the heart sounds and slows its action.

Drs. Azoulay and Jules Simon have employed this method in the Children's Hospital in Paris, and state that they have been able to localize obscure extra and intracardiac bruits, as the slowing of the heart's action and the augmentation of its sounds aided in clearing up their vagueness and complicated character.

It is said that dyspnœa and arythmia, without slowing of the pulse in the recumbent posture, and which do not occur in the upright, afflicting a person supposed to be in good health, indicate a lesion of the myocardium and a fatal issue from asystole may be predicted at an early date according to the degree of the disease.

If this be true, applicants for life insurance should be postured for examination; indeed, in all obscure cases diagnosticians could profitably utilize natural attitudes and assumed postures when conducting physical examinations.

Sims discovered and demonstrated the advantages of the side posture, still, with all that has been said and written, a comparatively small number of physicians employ it.

FIGURE 1.

Many specialists use the lateral position for ocular examination and treatment; the dorsal recumbent posture for executing bimanual examinations and perineal operations.

The vagina, in its usual, desolate condition, is a collapsed sack, preserved in its closed condition by pressure of the superincumbent, surrounding viscera, so that ocular examination cannot be made or local treatment applied without dilatation or expansion of this structure.

There are two methods of opening the vagina for these purposes, one is direct mechanical dilatation by means of cylindrical or valvulaspecula, the other is by elevation of the pelvis to induce prolapse of the viscera toward the diaphragm by the traction of gravity, at the same time retracting the perineum.

Dr. Joseph Price declares "that cylindrical and valvular specula do harm in the hands of the inexpert,

and the expert do not need them; that if ocular examination is necessary, or local treatment is indicated, the lateral position and Sims' speculum should always be used."

In the lateral position upon a horizontal plane the viscera still press upon the vagina, so that traction upon the perineum, and repression upon the anterior surface of the vagina are necessary to provide a free field for the purposes of inspection and treatment.

To carry out these manipulations requires the aid of a skilled assistant or a deft operator.

This obstacle is overcome by placing the patient in *the knee-thigh-chest posture*, described in the following paragraphs :

This position is not uncomfortable, and it combines the advantages of both the knee-chest and side (Sims') postures; it may be called The Exaggerated Sims'.

The Knee-Thigh-Chest Posture. — The patient mounts the steps with the left thigh toward the table, lifts her drapery upon the table's top in order that it may not bind her limbs as she reclines, or obstruct the operator. Reclining, she rests her left thigh across the table's end, carries her left arm backward, parallel with the body, places her left ankle upon the rest and draws the right limb over and beyond its fellow. She will posture herself unaided after one or two lessons.

The arms should not be carried upward as this movement draws upon the thorax, causing tension of the abdominal muscles. The head is placed upon a pillow, a little beyond the middle line, so that the body is slightly flexed, relaxing the abdominal muscles. The left thigh and leg are flexed to, or slightly beyond right angles, and the right are more fully flexed, the knee dipping downward. These flexures relax the pelvic muscles.

In this position upon a horizontal plane it is evident there is very little dip to the abdominal cavity, and its viscera moving by respiration in a horizontal line press upon the pelvic organs.

To avoid this the table top is given a double tilt. The high lateral tilt inclines the body so that the patient turns upon the left thorax and the knees rest upon the side rail, the longitudinal tilt accentuates this position, which gives a decided dip to the long diameter of the abdominal cavity and the viscera settle toward the diaphragm.

For this position, the side tilt should be raised to an angle of ten or more degrees from the horizontal line; the long tilt to an angle of five or six degrees; more than this, for the long tilt renders the patient comfortable and is unnecessary.

The tilting is to be done after the patient is placed as described. A line drawn through the sacral plane, or trochonters, transversely with the body, is at an angle of forty-five degrees; lengthwise with the body at an angle of six degrees from a perpendicular line.

Thomas made a study of this subject, and as a result of his experiments, constructed the gynecological table, which bears his name.

As bodies differ in conformation, set rules are modified in accordance with the tact and judgment of the operator.

The following cut illustrates the knee, thigh, chest posture, in which it will be observed that the body is comfortably supported by the knees resting upon a padded rail.

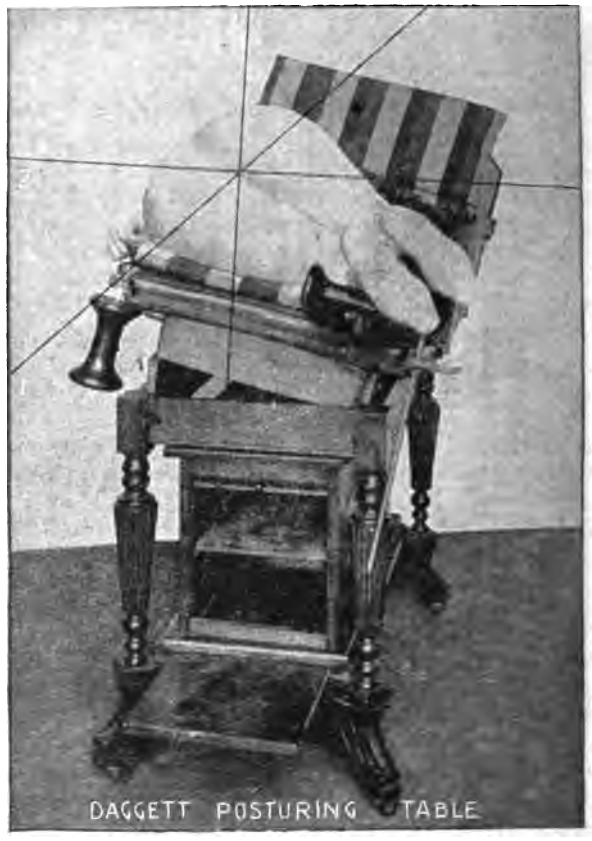

FIGURE 2.

258 FRANKLIN ST., BUFFALO, N. Y.

Typhoid Fever.

Read before the Military Tract Medical Association, at Canton, Ill., Oct. 19th, 1892.

BY W. S. STRODE, M. D., LEWISTON, ILL.

The epidemic of typhoid fever which I shall describe, occurred, with the exception of one case, in Fulton Co., Ill. The epidemic was remarkable for its contagious nature.

The initial case, Mrs. C., resided in McDonough Co., Ill. She died at the end of the third week after taking sick. She was about twenty-two years old, and previously had always been strong and healthy. I know nothing of the treatment of this initial case.

The next case was Miss D., a servant girl in the family of the deceased Mrs. C. A few days after the death of Mrs. C., she returned to her home in Fulton Co., eight miles distant. She soon took to her bed, and an irregular physician who had never seen a medical college, and was practicing under the ten year act, was called. As the patient continually grew worse for ten days, the family became dissatisfied, discharged the physician, and I was requested to assume charge of the case. I found a typical case of typhoid, temperature 104°; pulse, 120°; mild delirium at times; abdomen distended and tympanitic. The diagnosis of the physician previously in charge had been bilious fever. This case ran a typical course, recovering in about eight weeks.

At the end of the third week, a younger sister, aged seventeen, and a brother aged fourteen years, took down with fever. At the end of the fifth week, both were able to sit up, and walk about a little, and the sister went on to full recovery. The brother suffered a relapse from going out of doors in the rain, grew rapidly worse, and in spite of able counsel and all treatment, died in a few days.

Soon after the death of this lad, the other members of the family, father, mother, a son aged twenty-four, another aged five, and a daughter aged nine, were affected with the disease, and after comparatively mild attacks of it, all recovered in from six to eight weeks. In the meantime, other cases had developed among those who had attended the bedside of the initial case, Mrs. C. A married sister, aged about forty, who had nursed her for a week previous to her death, came down with it. The irregular, previously mentioned, was called, but she grew rapidly worse, and at the end of the second week, I was called as consulting physician. I changed the treatment to sponge bathing with cool water, and light doses of acetanalid once in four hours, with turpentine inunctions to abdomen, and two or three drops internally twice a day. On the third day, finding the patient was much improved and comfortable, the irregular now assumed the case again, and after my departure scouted the treatment that I had suggested, returned to his large doses of decoctions, composition tea, compound for canker, etc. The patient changed for the worse and died in three days.

Soon after all the children of the family, two girls and two boys, took the fever. A regular physician was employed, and after the usual time all recovered.

The fever now broke out in a neighbor's family, a brother and sister who had assisted in nursing the family last mentioned, being the first ones to take it. The family was poor, lived in a two-room log house, and the distance to the nearest regular physician was six or seven miles. The same irregular, who lived but a mile away, was employed, and attended them for three weeks. By this time four more of the family were down with the fever, making six in all. An all-wise and merciful Providence, just at this time, saw fit to call two of the sufferers to "join the great majority" "beyond that bourne from which no typhoid fever sufferer e'er yet returned."

The family was in a pitiful condition, without the necessaries of life, food or clothing, badly nursed, with insufficient nourishment, and unskillful medical treatment.

The epidemic had broken out in several other families, and there had been two more deaths.

The neighborhood was terror stricken, and it was a difficult matter to obtain volunteer nurses for those that were ill.

An appeal was made to the county in the case of the destitute family described, and the supervisor for the township was authorized to employ a competent physician, nurses, etc., and to supply the necessary food and clothing. Improvement at once was manifested, and in the due course of time all the six recovered.

In the meantime the fever had broken out in another neighborhood. An aunt of the servant girl first mentioned, residing eight miles away, visited her during her illness and remained two days and nights as her nurse. About ten days after returning home she developed the fever, which ran a typical course, recovering in about six weeks.

The children of her family, consisting of three males and three females—all grown but one—came down one after another, the disease running a mild course of from six to eight weeks, and finally all made good recoveries.

This epidemic commenced in November, 1890, and the last patient was discharged August 29, 1891, a period of about ten months. My connection with the epidemic extended over a period of about eight months, during which time I traveled in visiting those afflicted with the fever, over two thousand miles.

In all thirty-six persons had the fever. The number of deaths was six. Twenty-six were under my treatment with one death, and in this case, a relapse due to exposure after convalescence occurred.

An interesting feature of this epidemic of typhoid, was its peculiar contagiousness. The line of treatment which I particularly desire to emphasize, and which I applied, was the modified water bath.

Cold water sponging, whenever the temperature rose above 102. This treatment was kept up for twenty minutes at a time, and repeated until the temperature was reduced to 100 or 101. The nurses were given a fever thermometer, and instructed to take the temperature every two or three hours. The headaches were controlled by the same process, the application of cold to the head. Cloths wrung out of nearly ice cold water would be applied, and changed every few minutes until relief was felt. The patients were not required to eat much, in a large measure being allowed to decide when they desired nourishment. The nutriment was principally of a liquid nature, preference being given to a milk diet. They were allowed all the water or weak lemonade they desired. In some of the cases, a small amount of stimulants was permitted.

In about one-half the cases there was typhoid diarrhœa of a moderate character, this symptom usually appearing after some indiscretion in diet, usually following the ingestion of meat or solid food of some kind.

Nearly every case became very much emaciated before reaching convalescence and the demands of the "old granny women" sometimes became very urgent, that they be fed more or the patients would die of starvation.

But little medicine was used. Occasionally a few doses of antifebrin would be givenwith the result of lowering the temperature to the desired point, followed by profuse cold sweating and a feeling of exhaustion that was absent when the same result was produced by the cold sponging.

The treatment of pyrexia by the use of cold water immersions is undoubtedly the coming treatment.

It has been practiced in Germany for some time and is resorted to by the German physicians when the temperature reaches 101°. In America the patient is not immersed until a temperature of 103 is reached.

The water used is usually at about 65° F. and the patient is placed in it up to his neck and allowed to remain for fifteen minutes. He is actively rubbed during the whole time.

The great trouble with this treatment in the country and country towns is the objections of the patients and their friends. The greater number firmly believe that such treatment would at once shock them to such a degree that death would surely result.

The average physician is loth to insist on a treatment that will most surely end in his being dismissed from the case and a rival physician being called in.

And yet the statistics are not now wanting to show that this is the treatment par excellence over all other methods for the reducing of high temperature.

Dr. Chas. E. Page in the "Arena" for September says in writing on this subject quoting from Baruch a German statistician: "A treatment which shows one per cent mortality in one thousand two hundred and twenty-three cases of typhoid fever collected from five different sources, including private practice and civil and military hospitals may be regarded as nearly perfect."

Contrast this with the mortality of typhoid fever in ordinary practice, which is twenty per cent.

For seven years in Germany in the cold water treatment the rate of mortality has never gone beyond 4.7 per cent and the average has been 2.7.

Juergensen reports but one case in 217.

In the German hospital of Philadelphia where this treatment has been introduced Dr. J. C. Wilson reports sixty-four cases without a single death.

Dr. Baruch further says in writing upon this subject "We have it upon authority which we dare not question that the cold bath refreshes the nervous system; that it deepens the respiration; that it moistens and cleans the tongue; that it improves the appetite; that it steadies and slows the pulse; that it improves the digestion; that it increases the quantity and improves the quality of the urine; that it removes stupor and delirium; that it lends vigor and tone to the entire system and approximates the condition of the patientso nearly to the normal that his entire aspect is changed."

Yet notwithstanding all these facts and statistics, the average sick man is not yet ready to be plunged up to his neck into a tub of cold water.

It will yet require one or two more decades of hospital demonstration, and a few applications of the principle on physicians themselves before the dear sick public will consent to a treatment that to them seems so heroic.

For the present the nearest we can come to it, is the combined treatment of drugs and cold sponging.

Treatment of Empyema.

Read before the Military Tract Medical Association at Canton, Ill., October 19, 1892

By Dr. E. L. Mitchell, Roseville, Ill.

Empyema is an abscess of the plueral cavity, distending the serous membranes, compressing the lung, and accompanied by marked systemic symptoms such as fever and chills.

Aside from the debility caused by retention of pus, the lung by long compression becomes incapable of expansion and carrying on the function of respiration. The abscess if left alone will evacuate itself, but not until it has probably done irreparable damage. Its early recognition and treatment are of great importance. There is one matter that might lead to an error of diagnosis. One lung being compressed by the pus, the other is doing double duty in carrying on respiration, with a corresponding increase of the loudness of the respiratory murmur, which may be transmitted through the fluid, and heard over the affected area.

If the matter is in doubt, the needle of a hypodermic syringe, or an aspirator can be used, in fact, might be considered indispensable to a positive diagnosis, and if the proper aseptic precautions are observed, no harm will result even if the needle should penetrate the lung. Now it would seem that an opening for the drainage of the abscess cavity would always be indicated in the treatment of this condition, but cases are reported where aspiration alone has resulted in effecting a cure, and in cases of not too long standing it should be given a trial, the lung being expansile, it will fill the cavity and possibly result in the arrest of the secretion of pus. If necessary it can be repeated several times, and that failing a resort can be had to an operation for drainage.

In resorting to an operation for drainage, we can choose between the one of incision in the intercostal spaces, or the resection of a portion of a rib. An incision in the intercostal spaces will only permit of a very small drainage tube being introduced, and the pus often being loaded with thick shreddy deposits, it will be impossible to evacuate it without undergoing further disintegration, which will retard the patient's recovery. The best operation of the two is no doubt the resection of a rib, which will give ample room for the introduction of large drainage tubes and will greatly facilitate irrigation.

As to the fluid for irrigating the cavity, water that has been boiled is probably all that is necessary, and I would be afraid to use a solution of any of the stronger antiseptics for fear of dangerous absorption. Boracic acid would be harmless. Boro-glyceride has been used and advocated partly on account of its antiseptic properties, and on account of the weight of the liquid, displacing the pus, and floating it all out, which cannot be done by a watery fluid. What we should aim at is asepsis rather than the use of antiseptics. A very important matter is to use the irrigating fluid warm, as dangerous shock and sudden death have been reported from using too cool a solution.

On October 10, 1891, I was called to see a man, aged twenty-six, a miner by occupation, who with the exception of an attack of typhoid fever a few months previous, had always been healthy.

He had been thrown from a wagon by a runaway team about six hours before I saw him. He had a very feeble pulse, was suffering from shock, and was bruised over the side of chest and across his abdomen. The next day he had rallied, and I found he had a fractured rib, but was suffering the most pain in the abdomen. He did well apparently, and in two or three days I dismissed the case. Ten days afterward I was called to see him. He was complaining of pain on the injured side and difficulty in breathing; there was dullness on percussion over lower third of chest, and evidence of an accumulation of fluid. I introduced a hypodermic needle, but could not find any fluid. The second day from that I used the largest needle of an aspirator and withdrew over a quart of bloody serum. The next day his breathing was easy and he expressed himself as feeling well. I saw him again in three or four days and he had the same difficulty of breathing and pain in chest as before. Temperature 103°. I aspirated again, withdrawing over a quart of pus; repeated the operation in a week, then again in four days, getting an in-

creased amount of pus each time. I then told him it would be necessary to make an opening for drainage. I asked Dr. Talliaferro to see him with me. He advised the operation, and four days after the last aspiration I removed two inches of the sixth rib in the axillary line, raising the periosteum and making an incision through it, evacuating a large amount of pus. I introduced two large drainage tubes.

On the second day commenced irrigation, using a four per cent solution of boracic acid. He gradually recovered. The only incident worthy of mention was on the fifth day. The tubes were crowded out by a mass of membrane like tissue. The cavity gradually closed and the track left by the tubes soon healed by keeping them packed with iodoform gauze. When this patient received the fracture of rib there was in all probability a laceration of the intercostal artery. I do not think the aspiration could have caused the subsequent formation of pus as strict antiseptic measures were observed.

The deformity afterward was slight; the lung fully expanded, and the man worked on a farm during the spring and summer, doing a full man's work. Of course in a case like this aspiration would prove futile, but the delay in operating did no harm and in analogous cases it has resulted in a cure, and especially in cases of children has been favorably reported on, but if there is an increasing amount of pus, or it does not markedly decrease after two or three aspirations, an opening for drainage should be resorted to.

Urinalysis in its Surgical Relations.*

By G. Frank Lydston, M. D.

Professor of the Surgical Diseases of the Genito-urinary Organs and Syphilology in the College of Physicians and Surgeons; Surgeon to the Cook County Hospital.

Lecture I.

General Appearance, Qualities, and Unorganized Deposits of the Urine.

Gentlemen: The various standard treatises upon the special subjects included in the surgery of the genito-urinary organs do not devote much space to a description of the characters of the urine in the different diseases which come under the observation of the surgeon. Such attention as is given to urinalysis is principally incidental to a description of the various diseases of the genito-urinary tract, and is very meager. This seems somewhat strange, too, in view of the important information which may often be obtained from a careful study of the urine in different surgical diseases, particularly those involving the genito-urinary tract. It has therefore occurred to me that a little time should be devoted to the special consideration of the subject.

It is desirable for the surgeon to so familiarize himself with the gross physical characters of the urine in different morbid conditions that he can form a tolerably accurate estimate of the condition of the genito-urinary organs without an exhaustive chemical and microscopical examination. To pursue accurate investigations in the minutiæ of urinalysis, considerable technical knowledge of analytical chemistry and of the science of microscopy is necessary; but for the application of pathologico-chemical facts and the main features of urinary microscopy to the diagnosis of genito-urinary diseases, a moderate degree of familiarity with microscopical and chemical technique is amply sufficient.

Todd has wisely said that "although it is clearly a duty not to neglect any means of observation and investigation, it is desirable that you should be as little as possible dependent upon means which are not always at hand, and which it does not fall to the lot of every eye and hand to use with equal readiness and skill."* The greatest of modern pathologists, Prof. Virchow, has expressed himself in a somewhat similar manner as regards what he has aptly termed "naked-eye pathology." The experience of most practical pathologists is corroborative of the assertion of this eminent authority that microscopical characters may generally be anticipated by a conscientious and expert macroscopical examination.

It is not my intention to take up the subject of urinalysis in detail, nor indeed in general, excepting in so far as it applies more or less directly to surgical diseases.†

The quantity of urine varies greatly even in health, the amount excreted being dependent upon a number of circumstances; it varies considerably with the season of the year, being greater during the winter months. This variation is due to the difference in the activity of the skin in cold and hot weather. In the summer the rapid and profuse excretion of fluid by the skin diminishes the amount excreted by the kidneys; *pari passu* with this diminution in quantity, we note, *cæteris paribus*, an increase in the proportionate amount of excreted solids. The quantity of urine is obviously modified by the character of the food and drink. Vegetable diet, which contains a large proportion of fluid in its composition, produces a larger excretion of urine than does purely animal food. The amount of fluid ingested necessarily modifies the quantity of urine more than any other circumstance. The condition of the bowels modifies the quantity of urine. A patient with a diarrhœa is likely to excrete urine in scanty amount. This is well illustrated in Asiatic cholera, in which complete suppression of urine eventually occurs, being explicable in part at least, by the rapid removal of fluid from the blood by the alvine evacuations. The condition of the kidneys modifies the quantity of urine as well as its proportion of solids. Much depends upon the condition of the nervous system; vaso-motor disturbances being productive of an increase or decrease, as the case may be, in the amount of excreted urine. Thus, we have a condition of hydruria, or an excessive amount of watery secretion from the kidneys, in cases of diabetes insipidus, in which the daily urinary flow may amount to from 7,000 to 10,000 cubic centimeters, the specific gravity being very often as low as 1,002. Persons of a highly nervous or hysterical temperament are not infrequently affected by this condition.

*A lecture delivered at the College of Physicians and Surgeons, Chicago.

*Clinical Lectures on the Urinary Organs.

†The student is referred to Peyer's elaborate work upon Clinical Microscopy for illustrations of the various deposits which occur in the urine in health and disease.

There are numerous exhaustive treatises upon urinalysis, as well as some smaller handbooks which will be very useful to the student; Flint, Ralfe, Marshall and Smith, Haines, Deems, and Oliver have each published excellent little manuals on urinalysis. Neubauer and Vogel have recently published a most exhaustive treatise upon the subject.

It is a not uncommon experience for those who are subjected to mental strain or anxiety, or to the emotions of anger or fright, to have an enormous increase in the quantity of urine. Students undergoing the ordeal of examination are quite apt to be affected by hydruria. The term *hydruria* is properly applied only to that form of excessive urinary secretion in which there is a marked increase of fluid with a coexistent diminution of solids. When the increase of water is attended with an increase in the amount of urinary solids from exaggerated tissue metabolism, the condition is properly termed *polyuria*.

The proportion of solids contained in the urinary fluid is modified by the same influences as those which affect the quantity of the excreted fluid.

A very simple method of determining approximately the amount of solids in the urine is given by Flint.* The specific gravity of the urine is to be taken, and between 1,010 and 1,030 it will be found that the last two figures of the specific gravity represent tolerably accurately the number of grains of solids excreted in each ounce of the urine. By ascertaining the total number of ounces excreted in the twenty-four hours, we can readily determine with sufficient accuracy for practical purposes the total amount of solids excreted. This is important as showing whether the kidneys are performing their functions sufficiently well to obviate the danger of uræmia in certain diseases. In making this estimate of the quantity of solids excreted, it is necessary to take into consideration the quantity and quality of the food and drink. The determination of the amount of solids excreted during the twenty-four hours may be a very important consideration in connection with operations upon the genito-urinary organs. Indeed, it may influence us either to avoid or perform an operation in cases in which the amount of albumin is of negative importance.

The diet and exercise modify the amount of solids very markedly. Thus, a diet of highly nitrogenized food increases the amount of solids, and particularly urea, to a marked degree, causing a condition described by Fuller† as *baruria*, with a large increase in the total amounts of urinary solids. Urine of this character is very concentrated, and urates are usually deposited. This condition of the urine exists in what was termed by Murchison *lithæmia*. This state of the blood bears an intimate relation to urinary calculus and various irritative and inflammatory affections of the genito-urinary tract. Dr. Andrew Clark has described a condition known as *renal inadequacy*, in which there is a notable deficiency in the amount of urea excreted, without marked or constant change in the amount of fluid passed. He has failed to show, however, whether this condition depends upon insufficient renal action or upon deficient tissue metabolism. The quantity of urine and the proportion of fluid and solid ingredients, is one of the most important considerations to be brought to your attention in connection with the various surgical affections of the genito-urinary tract. If you are perfectly familiar with the conditions which modify the composition and amount of the urine, you will have gained a great advantage in the management of these diseases. Thus, in diseases of a calculus or inflammatory character, it is obvious that it is desirable to increase as far as possible the proportion of fluids and decrease the amount of solids. This may be accomplished by diet, rest, modification of exercise, hot baths, the administration of large quantities of fluid, and various diuretic remedies.

Another consideration is the condition of the digestive apparatus, for if the functions of the stomach and liver be impaired, there will be present in the urine more or less crude products of tissue metabolism. Thus, instead of complete metamorphosis, the termination of which should be the production of urea, we are apt to have as a result of imperfect preparation of the food by the digestive apparatus a cessation of the process midway with resulting formation of uric or lithic acid. This is one of the causes of lithæmia. It is to be remembered in this connection, however—and seemingly many writers upon this subject fail to appreciate this fact—that the quantity and preparation of the food for assimilation are not the only circumstances upon which lithæmia depends, for there may be a normal proportion of nitrogenized food and perfect preparation by the digestive apparatus which fails of its object because of defective tissue metabolism. It is necessary, therefore, in considering the ways and means of lessening the irritating properties of the urine, to take into consideration the amount and quality of the food, the activity of the digestive functions, and the activity of those physio-chemical changes, the function of which is the final disposition of the nutrient pabulum. This question is of more importance to the surgeon than is evident upon superficial observation, as will be seen in connection with the subject of urinary calculi.

The specific gravity, color and odor vary considerably, being dependent upon the same circumstances that affect the quantity of the fluid and its proportion of solids. Urine containing a large proportion of solids is of a high color, as a rule, and of a high specific gravity. The urine of hydruria is pale and limpid, and of a low specific gravity. This is seen in some cases of surgical and granular kidney. The urine of lithæmic or gouty subjects is of a high color and high specific gravity. Urine of a low specific gravity has comparatively little odor. Normal urine has a peculiar aromatic smell, which grows strong and pungent *pari passu* with an increase in its proportion of solids. Various diseases, and the ingestion of certain drugs, modify the properties of the urine just described. Blood and pus modify the odor to a certain extent, and necessarily modify the color in proportion to the amount of these substances present. Carbolic acid, the preparations of iodine, and santonin taken internally, modify the color of the urine. Certain articles of diet also modify it. Asparagus gives a peculiarly offensive odor and dark color to the urine. Diuretics of various kinds increase the proportion of water and consequently lessen the pungency of the urine and cause it to become paler. In a general way, the urine may be said to be irritating in proportion to its height of color and degree of pungency.

In a large number of observations upon subjects for life insurance examinations, I have noticed that the recent ingestion of malt liquor causes a marked diminution in the specific gravity of the urine as well as a relative increase in its quantity. This diminution in the specific gravity and increase in quantity is greater than could possibly result from the mere addition of an extra amount of fluid to the excreted

*Op. cit.

†Medico-Chirugical Transactions, vol. li.

urine. So closely associated in my experience are the ingestion of malt liquor and an abnormally low specific gravity of the urine that I immediately suspect, when the fluid has a specific gravity of less than 1,015 (and 1,010 is frequent), that the applicant has recently been drinking beer. In the majority of instances I find this suspicion verified upon inquiry.

Copaiba, cubebs, sandalwood, and turpentine—drugs which bear an important relation to genito-urinary surgery—markedly modify the odor of the urine. Normal urine has an odor *sui generis*, which has been described as of an aromatic character. Urine containing a volatile alkali from decomposition evolves a strong ammoniacal odor. When it contains a fixed alkali, however, the odor is faint and disagreeable, something like the urine of the herbivora. Urine containing phosphates, particularly the phosphate of lime, speedily decomposes, and has a horribly offensive odor.

The reaction of normal urine varies considerably at different periods of the day. The urine of fasting is generally quite acid, becoming neutral or perhaps faintly alkaline a short time after the ingestion of food. Bence Jones* explains this diminution in the acidity of the urine by the abstraction of acid from the circulation for the supply of the gastric juice. Roberts†, however, is inclined to regard the change from acid to alkaline as due to the introduction of alkaline bases from the freshly digested food into the blood. The acidity of the urine is markedly modified by the quality and quantity of the food, by exercise, and by various diseases of the genito-urinary tract. An excessive ingestion of nitrogenized food increases the acidity of the fluid to a marked extent. A vegetable diet renders it alkaline. Chronic inflammatory diseases of the urinary organs usually produce alkalinity of the fluid. Thus in chronic prostatic and vesical disease the reaction may be strongly alkaline, a decided odor of ammonia being perceptible. Strongly acid urine deposits urates upon cooling, while alkaline urine deposits phosphates. It is desirable sometimes to differentiate the alkalinity due to volatile alkali dependent on ammoniacal decomposition from that due to a fixed alkali (potash or soda). This is readily done by observing the behavior of litmus paper which has been dipped in the urine and allowed to dry. The blue color produced upon red litmus by ammoniacal urine disappears as the paper becomes dry, while in the case of the fixed alkali it persists.

The transparency of the urine is an important consideration. Urine, although dark, may be perfectly clear; while light urine, on the other hand, may be perfectly opaque, according to the presence or absence of extraneous matter or urinary deposits. Opaque urine may be very light or very dark. When of a light color it contains either earthy phosphates, mucus, or pus, singly or combined. Mucus is more apt to form a distinct cloud in the urine than is pus, which from its higher specific gravity sinks to the bottom of the vessel. This, however, depends somewhat upon the character and origin of the pus. For example: in pyelitis the pus is powdery and easily diffused throughout the fluid, while in cystitis or abscess emptying into the bladder it forms a more distinct layer. Purulent urine may, however, be completely opaque with a distinct, thick, yellowish layer of corpuscles at the bottom. When urine is turbid from either mucus, pus or salts, it may be filtered before examination. When the urine is of a dark opaque appearance it may contain blood or bile. Carbolic acid, chlorate of potassium and creasote poisoning make the urine very dark and opaque. Chlorate of potassium in poisonous doses imparts in some instances an almost black color to the urine.

Turbidity of the urine is often indicative of a diseased condition of the genito-urinary tract where no subjective symptoms of disease exist.

In an excellent article by Dr. P. S. Hayes,* attention is called to the relation of bacteria of various forms to more or less marked turbidity of the urine. Thus bacteria of various forms may be found in the urine in cases in which there are no definite symptoms of organic disease. The micrococcus urea, vibrios, rod-like bacteria, and spirilla are apt to be met with. The author found in one specimen six different varieties of bacteria within three hours after the urine had been voided. He states that "urine which is turbid when voided, and is not cleared on filtration, almost always contain bacteria."†

Independently of the presence of bacteria, turbidity of the urine is apt to indicate an unhealthy state of the mucous membrane, which may be the result of old organic disease, or of present slight disturbance which may later on become sufficiently marked to attract attention and to require treatment. Bacteria may be implanted upon the vesical mucous membrane by catheterization, and give rise to a low grade of irritation with the resultant formation of mucus, this condition being capable under favorable circumstances of progressing to actual catarrhal inflammation.

It is possible that our author's enthusiasm has led him to rather too arbitrary conclusions regarding the significance of slight turbidity of the urine, and a certain amount of allowance should consequently be made. The subject, however, is one which is well worth our attention. In making such observations great care is necessary as regards the cleanliness of our manipulations of the urine. I have recently made a little observation in connection with this that was to me very instructive as showing how rapidly the urine could become turbid after evacuation. In making life insurance examinations I had been in the habit of having the applicant void urine into a large mouthed bottle, from which I took a sample for examination. This bottle was thoroughly rinsed with cold water—which I deemed under the circumstances sufficient for cleansing—before and after use, on each occasion. I had noticed for some time that in quite a proportion of instances the urine was not as clear as could be wished, and upon microscopical examination of a few of the specimens I found some of them swarming with bacteria. It was noticeable that when the urine was examined immediately after being voided it was clear and did not contain bacteria. The explanation of the difficulty was finally found to be a slight accumulation of urinary sediment upon the sides and bottom of the bottle, which rinsing with cold water had been insufficient to remove. In this sediment bacteria had thrived and waxed fat, and when the healthy urine was voided into the bottle they very soon began to multiply very rapidly. Fre-

*Op. cit.
†Op. cit.

*Western Medical Reporter, September, 1888.
†Peyer makes a somewhat similar statement.

quent scalding of the vessel since the discovery of this fact has obviated further difficulty.

Persistent foam upon the urine (*i. e.*, foam remaining upon the surface for over half an hour) is an indication, as a rule, of either albuminoids or bile, or both. Mucus in moderate amount is also productive of persistent foam. This is suggestive in a general way of a catarrhal state of the mucous membrane of the urethra, bladder, pelvis of the kidney, or of structural renal disease. It is a point well worth remembering.

It is very useful to the practitioner to be able to form a general estimate of the character of urinary deposits from their gross appearance. Sediments occur in this fluid very frequently, and may be deposited in it before evacuation from the bladder, as is apt to be the case in certain forms of kidney and vesical disease, or they may appear only after the fluid has stood for a variable time. Thus, these various substances may be insoluble in the urine primarily, or they may be soluble in the warm fluid, but rapidly precipitated when it becomes cool; still other sediments result from chemical changes which occur with greater or less rapidity after the evacuation of the fluid. A deposit of a fawn color and of a more or less powdery consistency (when not mixed with mucus) appearing in the cold urine, but dissolving when it is heated, consists of the urates of ammonium and sodium. Cystin is another but much rarer deposit of a similar color, which is not dissolved by heat and is only slowly acted upon by alkalies. A heavy red, sandy deposit at the bottom of the vessel is composed of uric acid. This deposit is dissolved by nitric acid and by alkalies. Blood corpuscles may form a reddish deposit at the bottom of the fluid; the peculiar color giving a fair idea of the character of the deposit. A deposit of a whitish color not soluble in the heated urine, and often deposited by heating previously clear urine, is composed of the earthy salts (triple phosphates, phosphates of lime, oxalate of lime); the oxalate of lime and phosphates are differentiated by adding acetic acid, the latter deposit clearing up, while the former does not. A creamy white, ropy, or flocculent sediment is probably mucus; a greenish yellow deposit forming a sort of jelly with liquor potassæ is usually composed of pus or muco-pus. Long whitish strings or filaments often occur as a consequence of stricture.

The various urinary deposits require special consideration.

Urea is one of the most important substances for our consideration in connection with the excreted solids of the urine. It does not occur as urea in the form of deposits, but in chemical combination (urates). The reason for its nonappearance in deposits is its solubility. The quantity of urea excreted during twenty-four hours is the best criterion of the activity of the excretory function of the kidneys, and is of importance in its relations to both medicine and surgery. If in any particular case you have determined the amount of urea excreted, you are in a position to ascertain whether the patient is in danger of uræmia or not—in other words, whether the kidneys are properly performing their eliminative function. This question is worthy of your most careful consideration in connection with operations upon and diseases of the genito-urinary tract.

Urea represents the ultimate product of tissue metabolism, and its amount depends (1) upon the amount of nitrogenized material introduced into the system;* (2) upon the activity of physio-chemical transformation of the nitrogenized elements of the food after its digestion and absorption; (3) upon the actual amount of waste of the fixed tissues.

In all diseases in which fever is a symptom the excretion of urea is increased. Diseases of the liver modify the amount of urea, inasmuch as it is the organ in which the physio chemical changes which tend to the formation of urea are the most energetic. In hepatic abscess, and in cancer of the liver, a notable diminution is observable. The various forms of surgical disease of the kidney itself lead in a general way to a diminution in the excretion of urea.

For ordinary purposes it is not necessary to resort to the intricacies of quantitative urinalysis to determine with sufficient accuracy for practical purposes the amount of excreted urea. If the total quantity of urine be normal, or nearly so, and the specific gravity of the urine is not appreciably lowered, it may be inferred, if sugar is not present, that a sufficient amount of urea is being excreted to fulfill the needs of the economy. If the specific gravity is low, but there is a compensating increase in the total amount of excreted urea, we are also justified in believing that there is no imminent danger of uræmia. Due consideration must, however, be given to the amount of fluid ingested, and the amount and quality of the food.†

Uric acid was formerly thought to be the characteristic element in the composition of urinary calculi, hence it was called lithic acid. Since the discovery of this substance, however, more than one hundred years ago, it has been shown to bear an important relation to gout, and inferentially it has been demonstrated that a gouty or lithic condition of the blood is the foundation for many cases of urinary calculi. Dr. Garrod in particular has dwelt upon the association of uricæmia with gout, and has shown that an excess of uric acid is present in the blood during an attack of that disease.

Uric acid may be described as a midproduct of tissue metabolism; it is the result of imperfect oxidation of those nitrogenized elements of the food which should be converted, on the one hand, into substances ready for assimilation by the tissues, and upon the other into urea. Uric acid bears an important relation to the surgical affections of the genito-urinary tract; the severity of all inflammatory affections being to a certain extent dependent upon its amount, not only as present in the urine, but as present in the blood—not that the acidity of the urine is dependent upon uric acid, but that urine containing an excess of this substance is heavy and irritating by virtue of the mechanical effects of the crystals themselves. The intimate association of uric acid and the urates with urinary calculus is familiar to every practical physician and surgeon.‡

The close association of uricæmia with gout, is well illustrated by the fact that the so-called gouty depos-

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*According to Flint, a purely animal diet increases the amount of urea excreted two-fifths, while a nonnitrogenized diet reduces it one-half; purely vegetable diet reduces it one-third.

†General nutrition may be so modified that comparatively little urea appears in the urine, yet this small amount represents all, or very nearly all, that is formed in the system; this is the salvation of some patients with surgical kidney.

‡Of 184 stones removed by Sir Henry Thompson by lithotrity, 122 were composed of uric acid and urates.

its or tophi which occurs in the joints, the cartilages of the ear, and in the tubuli recti of the kidney, are composed of sodium urate. Uric acid requires for its solution something like 15,000 parts of water, in this respect differing markedly from urea, which is very soluble. Thus, when the urine is very concentrated, and the amount of water much below the normal standard, the deposition of uric acid is likely to occur. Uric acid and the urates may vary in quantity by modifications of diet. Uric acid when deposited in the urine in a free state resembles in appearance brick dust or red pepper.

Oxalic acid in the form of oxalate of lime has given rise to considerable controversy regarding its origin among those interested in genito-urinary pathology. It has been generally held that oxalate of calcium as a urinary deposit is a derivative of the decomposition of uric acid after its excretion, thus implying that the crystals of oxalate of lime signify only an excess of uric acid. It has been assumed by those who accept this view that oxalic acid (*i. e.*, oxalate of lime) bore the same relation to uric acid that uric acid does to urea. This hypothesis would imply that the process of oxidation if stopped at a certain point produces oxalic acid; a little further on, produces uric acid, and when perfected, urea. *Per contra*, in order to obtain oxalic acid from uric acid it is necessary to oxidize it more completely. The determination of the precise influences which produce oxalic acid in the tissues is necessarily a very difficult matter. In spite of all theories which have been advanced in explanation of the origin of this substance, we have as yet been unable to say more than an excess of oxalic acid in the blood, and of oxalate of lime in the urine, is a consequence of certain undetermined perversions and modifications of tissue metabolism.

A small quantity of oxalic acid is present normally in the blood, and is discovered in the form of oxalate of lime in the urine as a consequence of numerous circumstances. Its presence may be due to: (1) An ingestion of an excessive quantity of food substances containing the oxalate of lime, *e. g.*, certain vegetable matters such as rhubard, tomatoes, turnips and onions; rhubarb containing a large quantity of this substance. (2) From imperfect oxidation of starchy and fatty food materials, which before their final transformation into H_2O and CO_2 pass through transformations in which they present themselves as organic acids, *i. e.*, oxalic, lactic, ahd glycocolic acid. (3) An increase in the physio-chemical activity of the tissues. This involves the question of exercise and of hypermetabolism of tissue due to certain nervous influences. (4) It has been asserted that oxalate of lime may be derived from the mucus of the genito-urinary mucous membrane. The only way that this could occur would be through acid decomposition excited in the urine by the mucus. This theory of the origin of oxalic acid, although advanced by an excellent authority (Meckel), is evidently purely theoretical. (5) An excess of acid in the blood and tissues as a result of butyric and lactic fermentation in the alimentary canal. These substances being absorbed, are not completely oxidized or transformed into CO_2, and as a consequence the midproduct, oxalic acid is formed.*

The presence of oxalic acid has been claimed by certain observers to bear a certain relation to diabetes. Thus Cantani asserts that he has noted an alternation of oxalate of lime and sugar in the urine. Fürbringer discovered oxalic acid in the sputum of a patient suffering with diabetes.

The excretion of oxalic acid has received considerable attention. When present in excess it has been supposed to signify abnormal conditions of tissue waste, and has been described as a distinct disease, *oxaluria*. While unquestionably the presence of the crystals of oxalate of lime in the urine may produce irritation of the mucous membrane of the genito-urinary tract, with frequent micturition and pain in the back, I am satisfied that the importance of the substance has been greatly overestimated. It is hardly fair to ascribe a severe pain in the back, accompanied by an excess of oxalic acid in the urine, to the irritation of this latter substance in all cases, for the relation of cause and effect is difficult to demonstrate. Such diagnoses are apt to lead to a confusion of *propter* and *post;* in other words, the pain and oxaluria may both be dependent upon actual renal disturbance.

Oxalate of lime is associated with one form of urinary calculus (the mulberry) which is composed nearly or quite entirely of that substance. Oxaluria is apt to be associated with certain conditions of digestive disturbance and nervous depression.

Phosphoric acid in the form of the phosphates is a frequent and important form of urinary deposit. The triple phosphate or ammonio-magnesian phosphate is the most frequent form, the phosphate of lime the rarest. The acidity of the urine is dependent upon the biphosphate or acid phosphate of soda.† Phosphates are not deposited as long as the urine remains acid, but as soon as it becomes alkaline a deposit speedily occurs, whether the phosphoric acid in the urine be in excess or not. The principal surgical importance of the phosphates consists in their relation to urinary calculus, hypertrophy of the prostate, chronic cystitis, and pyelitis. Whenever the urine decomposes as a consequence of an excess of mucus or of prolonged retention, a deposit of phosphates occurs. If a foreign body be present, this deposition of phosphates occurs about it, and solidifies, eventually forming a calculus about the nucleus; thus, it may form about a uric acid or oxalate of lime gravel that has come down from the kidney, a clot of mucus, or a foreign body introduced into the bladder from without. The addition of an acid to phosphatic urine clears it up immediately.

Zanthic oxide or zanthine presents itself in the urine as a very rare form of urinary calculus. Cases of this kind have been reported by Langenbeck and Bence Jones. Such cases have been seen in young subjects.

* Lehmann admits that oxalic acid is formed spontaneously in the system under certain pathological circumstances, and explains its occurrence upon the basis of a modification of the function of respiration. By virtue of this perturbation, carbonic acid remains in excess in the blood and inhibits oxidation. Debout D'Estrées (*Medical Record*, Dec. 8, 1888) asserts the common origin of the uric and oxalic acid diatheses, and claims that the same conditions which induce uricæmia will in the presence of nervous perturbation cause oxalæmia. This seems logical enough, for certainly trophic disturbances *i. e.*, perturbations of metabolism—modify the results of the metamorphosis of nitrogenized food pabulum.

†Flint, *op. cit.*

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D.,
HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Dr. W. L. Copeland.

Dr. Copeland was born in 1850 at St. Catherines, Ontario, where he attended the public and high schools till prepared to enter McGill College. After taking his literary degree he entered upon the study of medicine and passed the examination of the College of Physicians and Surgeons of Ontario. Desiring to perfect himself in Old World methods, he entered St. Thomas Hospital, London, and remained one year; at the end of which time he secured his M. R. C. S., Eng. On his return to St. Catherines his attainments were recognized and he was placed in charge of the General and Marine Hospital which position he filled till his removal to Chicago in 1879.

Dr. W. L. Copeland.

When the College of Physicians and Surgeons of this city was organized, Dr. Copeland became a member of the dispensary staff. In 1884 he became professor of anatomy in the Chicago College of Dental Surgery, which position he still holds. He resides at 866 West Monroe St., where he has built up an excellent practice among the best classes. He was married to Miss Mary St. John, a sister of Dr. Leonard St. John, in 1876, and has two daughters.

Our British Visitor.

There came among us a short time since the mightiest light of European medical journalism. This light has blazed with such effulgent radiance that the average American medical editor has shrunk into nothingness. He has also apparently been compelled to wink so hard that he has failed to appreciate anything but the greatness of our guest. Far be it from us to belittle the mighty reputation of the celebrated editor of the *British Medical Journal*. We are well aware that the WESTERN MEDICAL REPORTER bears the same relation to the ideal journalism, represented by the distinguished editor aforesaid, that the productions of Buffalo Bill and John L. Sullivan bear to the legitimate drama; but we have none the less been rather impressed with the idea that at times our distinguished visitor has been so "intoxicated with the exuberance of his own verbosity," that he has forgotten that while he has been seeing us, he has been exposing himself to the danger of being seen and heard.

Some of the remarks made by him anent medical journalism, American sanitary problems and Chicago water, have been singularly devoid of logic, and have presented an assumption of knowledge of things of which he is of necessity comparatively ignorant, which, were the circumstances reversed, would be considered a piece of arrogant presumption. We can assure our distinguished visitor that had he not been a guest of the profession in this county, many of his remarks, and some little discrepancies in his etiquette, would not have been allowed to go unchallenged. Overwhelming arguments could be advanced against certain statements which have been made by him, and he must not imagine that he has gone unscathed because of the overwhelming weight of his opinions. We remember quite vividly certain criticisms that were passed upon several American surgeons whose conduct while in England some time ago, was said not to have been quite up to the ideal standard of English etiquette. We believe, however, that whatever the discrepancies of these American gentlemen may have been, even granting that the English view was correct, they did not visit England as the typification of all that is ideal in medical literature, professional ethics or scientific wisdom. We wonder if at any time any of our prominent American physicians who have been visiting Great Britain have ever presumed to interfere as offensive partisans in the politics of the British Medical Association? We wot not. If we remember correctly, however, considerable attention was paid by the editor of the *British Medical Journal* in his discourse at the banquet of the American Medical Editors' Association at Milwaukee, to the ethics of the American Medical Association. This was a breach of etiquette, which could not be condoned, as by far the majority of his hosts who were present at that entertainment, were most decidedly not in accord with the ultra-ethical medical orthodoxy which Mr. Hart expressed in his otherwise exceptionally able address. Many also have since asked why he allowed himself to be made a puppet to dance to the music of certain politicians in the American Medical Associations. He might have remained his own mouthpiece, and yet sufficiently

irritated a majority of the members of the American Medical Editors' Association.

Some of his remarks anent medical journalism were in decidedly bad taste. It is all very well for the editor of a great and prosperous medical journal to scorn the flesh pots of Egypt; it is all very well for a man of almost unlimited editorial power and practically unlimited means, to say that medical journalism should be shorn of its business features. If, however, the *British Medical Journal* had been shorn of those elements which have tended to its financial prosperity, what would have become of its mighty editor? We are reminded in this connection of a certain old deacon of a village church, noted for his wealth and parsimony, who, when the poor struggling parson complained that he could not live on $400 a year, said that he thought any reasonable man could do it, especially with a donation party thrown in. We might also remark for the benefit of those of our English brethren who so frequently undertake the regulation of our professional and social etiquette, and who consider themselves the beau ideals of social propriety, that it is not exactly in good form to keep a dinner party of ladies and gentlemen waiting for a full hour for the arrival of a distinguished guest whose bounden duty is to be on time.

We might also further remark that the invitation to partake of the hospitality of the Chicago Commissioner of Health did not specify the privilege of keeping a boat load of professional gentlemen, whose positions were quite as distinguished as that of our English friend—and whose time is vastly more valuable—awaiting his lordly pleasure for at least an hour and a half.

A recent incident has placed our British visitor in a rather unenviable position. According to the Chicago daily press, he happened to be present, not by invitation it is said, at the congress of Psychical Research, recently in session in this city. He took issue with some remarks that were made, and although totally ignorant apparently of the aims and objects of the congress, not only made a very lengthy speech—against the protests of the chair, who ruled him out of order—but wound up with a wager against the competency of any member of the Society for Psychical Research to produce an evidence of mind-reading ability. It is said that considerable and rather forcible persuasion was necessary to induce our distinguished guest to relinquish the floor. We do not know yet whether he has discovered that the society for Psychical Research is not one for the promotion of mind-reading or clairvoyance, but we trust he will be enlightened upon this subject ere he leaves our shores.

Be it understood, that we have the utmost respect for the ability and professional position of the distinguished editor of the *British Medical Journal;* but we respectfully insist that American physicians are by no means ignorant of social amenities, and that they know something of sanitary problems, and possibly of medical journalism. We feel that he has been hypercritical, and not particularly generous in his estimate of things professional and scientific in America, and we would respectfully suggest that he continue his observations but along broader lines and with a greater degree of respect for the feelings, scientific knowledge, and breadth of culture of his American confréres. American physicians and surgeons—aye, even the average American physicians—are the peers of any in the world. American medical editors are certainly as talented upon the average and certainly of far broader intellectual capacity than any of the samples yet submitted for our inspection by the other side of the water.

Anent the somewhat erratic conduct of our distinguished guest at the meeting of the Society for Psychical Research, we will call his attention to a production of that celebrated American poet of whom we are justly proud, Mr. Bret Harte, entitled, "The Society Upon the Stanislaus." We would call his attention particularly to the stanza in which Truthful James remarks:

"Now, I hold it's not the proper plan for any scientific gent,
to whale his fellow man;
Or if a member don't agree with his own peculiar whim,
to lay for that same member to put a head on him.
Nor is it ever proper for a scientific gent,
to say another is an ass, at least to all intent;
Nor should the individual who happens to be meant,
reply by heaving rocks at him, at least to any great extent."

Abstracts.

Medicine.

Whooping Cough in an Infant Eighteen Days Old.—On the 25th of June, 1893, I was called to see a child, eighteen days old, said to be suffering from whooping cough. I found a family of seven children, three of whom were coughing characteristically with whooping cough. Two had been coughing for about three weeks, and one other, I afterward learned, came down in a few days. The babe I was called to see, was having paroxysms of strangling or coughing, at intervals of three or four hours, accompanied by asphyxia. Between these paroxysms the child lay comatose, without inclination to nurse, and when an attempt to feed it was made a paroxysm of choking would occur, accompanied with cough. These symptoms had been increasing for three or four days. My prognosis was unfavorable. The child died the following day in a paroxysm. There were unmistakable symptoms of the disease for fully one week previous to its death.

Did the mother receive the poison in her system before the birth of the child, and communicate the disease through the blood to the fœtus? Some of the older children had had the disease years previously, but were now coughing, undoubtedly from inhalation of the atmosphere contaminated by those having the disease. The mother had some slight persistent cough similar to the others, but without the whooping. This case was the youngest subject I ever saw affected with the disease; but there was not the slightest doubt about the character of the trouble.—*Currier in Med. and Surg. Reporter.*

Antidote for Carbolic Acid.—An Italian tailor swallowed by mistake thirty grammes of carbolic acid. Dr. Moreit, of Ancona, using a rubber catheter, immediately introduced by slow degrees into the patient's stomach a strong solution of sulphate of soda, which forms with carbolic acid a harmless mixture. In an hour's time the patient, who had been in a most critical condition, began to revive. Inhalations of am-

monia were then used to hasten up the process, and little by little the poisoned man rallied so that an emetic, followed by a dose of lime water, finished the cure.—*Med. Times.*

BACILLI AND NITRIC ACID.—Bacteriologists have been for some time familiar with the fact that the common bacilli produce nitric acid and nitrite, but instead of seeking in these secretions the cause of the distructiveness of the microbes, they have directed their attention chiefly to the poisonous albuminous substances they have discovered in "cholera culture," but which prove to be the contents of the cells of the dead bacilli, and therefore perfectly harmless so far as the genesis of the disease is concerned. It is the active product of their vital function, and not any lifeless residuum of decomposition and decay that works the mischief. By a series of experiments on rabbits, Profs. Esmerich and Tabor have shown in a Munich journal of the 10th of June, that the symptoms of cholera and of poisoning by nitrite are perfectly identical in their action on the blood, and on every part of the organism. These statements of the learned professors are undoubtedly correct, and in looking to the ptomaines for the deadly poison, there is opened a very important avenue for the therapeutic study of the disease.—*N. Y. Med. Times.*

DIAGNOSIS OF DIPHTHERIA.—H. Bourges, M. D., Paris, France, (*International Medical Magazine*) contributes a valuable article on the differential diagnosis of diphtheria, and enumerates the differential signs as follows:

1. At the advent of scarlatina the false membranes assume a lustrous hue, white and not gray as in diphtheria; they are friable disintegrate when any attempt is made to detach them, and cannot therefore be removed in large strips. This is true of scarlatinal pseudo membranous angina on the first and second day, it ceases to be so afterward. Besides, does not diphtheria also give us false membranes that are quite white in color?

2. The soft palate and the uvula are only invaded in diphtheria. Numerous bacteriological researches have proved the contrary.

3. Scarlatina anginosa leads to necrosis of the mucous membranes invaded, and ulceration often accompanies the pseudo-membranous formation. This ulceration is often difficult to see, but ulceration may complicate, exceptionally it is true, real primitive diphtheria.

4. Glandular enlargement of the submaxillary region may terminate by suppuration in scarlatina anginosa. But is it not so also in diphtheria?

5. Albuminuria is rarer in scarlatina than in diphtheritic croup. That is certain, and still albumen may often be detected in the urine at the very outset of scarlatina.

6. The general health is much less disturbed than in diphtheria, paleness less marked, the strength much less depressed. This is certainly one of the best diagnostic signs, and yet there may be cases of mild diphtheria that evolve without much disturbance of the general health. On the other hand, the septic form of scarlatina anginosa makes the general symptoms as bad as possible.

It is easy to see from this discussion of the subject that a diagnosis is very difficult in such cases, if not impossible in some, when we have two affections that offer so many analogies.

We know that there is a form of puerperal diphtheria in which true fibrinous false membranes may be observed on the vulva, the vagina, and the mucous membranes of the uterus and tubes, which often leads to suppuration. This fibrinous exudation has many points in common with the products of diphtheria, but M. Widal has been able to show its complete independence by proving that while the false membranes of diphtheria are formed of Loeffler's bacillus, those of puerperal infection are due to the streptococcus pyogenes.—*N. A. Practitioner.*

CHLOROBROM IN SEA SICKNESS.—I used chlorobrom in all cases of seasickness to which I was called while ship's surgeon to the S. S. *Rimutaka* during a voyage to and from New Zealand, and I now desire to state my experience as to its action. I always gave it in three-drachm doses in the second stage of this distressing ailment, when retching, headache, depression and sleeplessness were the prominent symptoms, the hour selected for administration being 10 P. M. in order to secure a good night's rest. The results were very satisfactory. The chlorobrom was always retained and was always followed by sleep (generally sound). The patients awoke much refreshed in the morning, with an appetite and able (except on one occasion) to eat and retain something light.—*Hutchison in Lancet.*

DUNHAM'S TEST FOR CHOLERA.—In an article in a recent number of *La Semaine Medicale*, Prof. Koch approves of Dunham's test for cholera, known as the "Red Cholera Reaction," which according to Prof. Koch, is conclusive, provided the following rules are regarded:

"In the first instance care should be taken to select a good preparation of peptone, for all peptones are not equally well adapted for this test. The variations observed are probably due, as was pointed out by Bleisch, to a difference in the quantity of nitrates present. The delicacy of the reaction can therefore be increased by raising or lowering the proportion of nitrates in the peptone solution, as was suggested by Bleisch. It is also essential that the sulphuric acid used should be free from all trace of nitric acid. Moreover, success depends on a third condition, viz., the cultures of cholera bacilli employed should be absolutely pure, for with mixed cultures the results remain open to the objection that the indol and nitrous acid which gave the characteristic red coloration were the products of the secretion of other organisms than those of cholera.

"Cholera cultures in broth never give, even in the presence of peptone, a very distinct and uniform reaction. Hence, the test should only be performed with pure cultures of the bacilli in sterilized peptone solution."—*Mod. Med. and Bact. World.*

IMMUMITY AGAINST DIPHTHERIA.—Bardach has recently shown (Wratch, No. 6) that the serum of dogs, rendered immune by repeated inoculations, may be used for rendering immune the rabbit, the guinea pig, and the mole. It may also be used curatively, the infected animals being inoculated by subcutaneous injections of dog serum, it is found to be perfectly innocuous.—*Mod. Med. and Bact. World.*

PAROTIDITIS COMPLICATED BY ORCHITIS, PROSTATITIS, AND HEMOPTYSIS.—Comby (*L'Union Medicale*) has reported the case of a gardner, twenty-nine years old, who, after having worked all day in a hot house, was seized at night with a chill; the right testicle was noted to be swollen, red, heavy and painful. During the night there occurred sweats, with headache, pain in the back and in the extremities, so that sleep was prevented. There was also evidence of the existence of a mild prostatitis. On the following day delirium set in, and a day later still painful swellings appeared in both parotid regions. There were fever and dyspnea, and in the midst of a paroxysm of coughing, profuse hemoptysis occurred. Improvement now soon set in and in a short time the man was convalescent. Examination of the chest failed to disclose evidence of organic disease; neither did the urine present any abnormality. The treatment employed consisted in the administration of quinine sulphate, purgation, the application of emollient compresses to the testicles, and a milk diet.—*Med. and Surg. Reporter.*

STUDIES ON THE CLINICAL PATHOLOGY OF IDIOCY WITH RESEARCHES ON THE NORMAL ANATOMY OF THE CORTICAL SUBSTANCE OF THE BRAIN.—Carl Hammanberg has attempted to establish a clinical pathological classification of the various forms of idiocy. His results may be thus summarized: In all the cases examined by him, representing the chief groups of idiocy, the author was able to explain the psychical defects by a deficiency in the nerve-cells capable of performing their functions in the cerebral cortex, and to show that the brain-cortex had been checked in its development at a certain stage. If this interruption of development has taken place in the latter part of fœtal life, and the greater part of the brain-cortex has not reached a higher development than the cortical substance in the normal brain, the patients have no trace of consciousness. Psychical development is impossible. To this class belongs the group called "naturals" by the author.

If arrest has taken place during fœtal life or the first year of life, and the greater part of the corital substance of the cerebrum has not reached a higher development than is observed in the first years of life, the patients are not devoid of consciousness and conception, but the psychical development remains as it is in the normal child in infancy. To this class belong the feeble-minded to a high degree.

If development has been arrested during the first year of life, and but a small portion involved, while the greater part of the cortex is completely developed in every respect, except as to the number of cells, which are less than normal, the psychical function is slower than normal, but the patient is not in the same mental condition as the normal infant. To this class belong the feeble-minded to a moderate degree.

According to the territory of the brain in which development had been arrested, there arise disorders of motility or sensibility, and of the nerves.—*Academical dissertation Universal Med. Journal.*

SCIATICA.—Dr. S. Weir Mitchell says: "In any obstinate sciatica where I can exclude spinal cord disease, constitutional states, tumors, etc., I put my case in bed. Then I give codliver-oil, iron at need, full diet, and milk between meals. A long flannel bandage is put on at once rather tightly from the foot to the groin, and renewed twice a day. At the side of the limb a long splint is secured by a few turns of bandage. The splint should reach from axilla to ankle, the knee being bent a little, the heel secured from pressure. The splint and bandage are kept in place two to four weeks, night and day; daily, when these are removed, the leg is slowly and very moderately flexed and extended. The treatment is in constant use at the Infirmary for Nervous Disease. If it fails, it is usually because the malady is at first, or has become, spinal. The *rationale* of its use is, I think, clear: 1. The flannel bandage lessens the blood in the leg. 2. It protects the whole skin surface from the excitation of contacts. 3. The enforced immobility makes all motion impossible, and so the two uses of the nerve cease. It is in splint and we get physiological rest. Since I have used the bandage the cumbersome use of ice along the nerve-track is less often required. At the close of the treatment, massage used with extreme care may hurry the recovery."—*College and Clinical Record.—Med. Bulletin.*

THE EFFECT ON SUCKLINGS OF PURGATIVES ADMINISTERED TO THE MOTHER.—Gow, of London, was inspired by the experiments of Fehling upon the appearance of certain drugs administered to nursing women in the milk to the investigation of the effect upon the nursing infant of purgatives administered to the mother. Four drugs were selected, aloes, senna, cascara sagrada, and sulphate of magnesium. In all cases the frequency of the action of the bowels was noted before and after, in both mother and child, and the trial extended over a period of a week, and in some cases longer. The observations were simply clinical, no attempt being made to determine whether the drugs given appeared in the milk. The infants varied in age from three weeks to ten months. Eleven observations were made with senna, administering ten grains once a day, and in a few cases oftener. With one exception the child's bowels were unaffected, and in the exceptional case they were "less costive than before."

Ten observations were made with aloes, administering 2.18 grains of Barbadoes aloes, combined with extract of nux vomica once a day, in five cases, and twice a day in the remaining five cases. In eight cases the child's bowels were unaffected; in one case the child became more costive, and in one case the bowels acted more freely.

Ten observations were made with cascara sagrada, In doses of two to five grains of the solid extract, and one-half drachm of the fluid extract. In eight cases the children's bowels were unaffected; in one they became more costive, and in one case less costive than before.

Eleven observations were made with sulphate of magnesia, administering one drachm three times a day. In five cases the children's bowels were more freely opened than before; in one case the child became more costive.

These observations show that sulphate of magnesia, administered to the mother, leads to purgation of the child in nearly half the cases; senna, aloes and cascara sagrada seem only occasionally to produce this result, and therefore may be considered most suitable remedies for constipation in nursing women. —*The Practitioner.—Univ. Med. Journal.*

PRICKLEY HEAT.—Dr. Pollitzer finds that in prickly heat the horny layer of the epidermis is swollen by imbibition of water, the rete Malpighii slightly œdematous and containing cystically dilated sweat ducts, the blood vessels of the papillary layer gorged. His view of the etiology of prickly heat is that it develops on a skin soaked in perspiration and insufficiently supplied with fat. He recommends patients suffering from it in summer in hot climates to anoint the regions usually affected with a fat after the morning bath, the fat he advises being lanoline with the addition of a little almond oil.—*Jour. of Cut. and Gen. Urin. Dis.*

Surgery.

TUBERCULOSIS OF THE ANKLE JOINT.—Dr. Knut Hoegh, *N. W. Lancet*, concludes a study of this affection with the following summary:

Cases should be divided as to severity, age and the social condition of the individual.

The milder cases, such as show no great swelling, no particular abscesses, no fistulæ, no great pain, should be treated by iodoform injections, followed by absolute immobilization and complete rest of the extremity.

In children the chances for good results from this conservative treatment are better than in adults. Even these milder cases are apt to lead to general tuberculosis, which seems to be a more frequent consequence of disease in the ankle joint than in any other.

Furthermore, people in favorable economical conditions who can afford to give the extremity protracted rest, and who can put themselves under the most favorable hygenic surroundings, may try conservative treatment, while poor people who have to work, and who cannot go to health resorts, the sea shore, or to high altitudes, and who cannot always supply themselves with the best food, will do better in early submitting to operative interference.

The severe cases that have lasted some years, in which there is great destruction of the joint, with cold abscesses, fistulæ, pain and redness indicating mixed infection, justify amputation, particularly in persons beyond the period of adolesence, and in poor individuals who cannot afford to give the necessary time to long treatment and rest of the joint, and whose hygienic conditions as to lodging and nutrition are defective. Persons with visceral complications should also be advised to submit to amputation.

Between these two classes there is a group of cases which justify resection or arthrectomy. They are the cases where either immobilization and rest has been useless and the disease progresses in spite of it, or cases that came under treatment comparatively early, before great destructive processes have yet taken place, but where the existence of a local osseus focus is suspected, from limited but acute tenderness on direct pressure by the surgeon's finger, or by bringing adjoining bone surfaces into forced contact.

As a rule I should advise against resection and amputation in the presence of a fistula or denuded carious bone; but where in exceptional cases, the bone disease was limited and only two or at the most three of the joints implicated, I would try resection.

In case of resection I should demand, besides the strictest conformity to the technique of modern antiseptic surgery, a complete exposure to view of the diseased joint, so that complete removal of the diseased tissue could be secured.

LARGE DOSES OF CREOSOTE.—In the *Indiana Medical Journal*, Dr. Guido Bell advocates the use of creosote in tubercular affections. He administers twenty a day in combination with comp. tr. cinchon., diluted with milk. He says: I have seen three cases of suppurating glands which yielded to the local treatment only when combined with large doses of creosote. In one case there was an extensive ulceration of the vocal ligaments, a constant cough, and extreme debility. Within three months the young man gained twenty-five pounds in weight under the creosote treatment. His voice was only occasionally hoarse, and the rattling tympanitic noise on his right lung appeared only once after a cold; the fistula on his right cheek from the suppurating gland closed up nicely.

I firmly believe that creosote is a curative in pyemia, and a preventive of a possible tubercular affection. I have dispensed two pounds of beechwood creosote in my office within the last three years; therefore, I claim some knowledge in regard to its dosage.

TREATMENT OF STRICTURE OF THE FEMALE URETHRA.—Dr. W. A. Meisels thinks that more attention should be paid to strictures of the urethra in females, as he is certain that numerous cases of vesical neurosis and dysuria and the associated reflex neuralgias, which at present are treated symptomatically, can be cured by urethral treatment. As regards the operative methods of treating urethral strictures in females, he believes that gradual dilatation with sounds (preferably Hegar's sounds) in several sittings, usually brings about the desired result, and that it is rarely necessary to resort to the knife. To prevent recurrences it is necessary to introduce sounds from time to time. The use of the endoscope for diagnosing the nature of extent of the urethral lesion is of great advantage.—*Wein. Mediz. Wochenschr., Int. Jour. of Surgery.*

TREATMENT OF GONNORHŒA.—Gebert describes the following treatment which is employed at the Polyclinic of Dr. Blaschko: In recent cases no injections, but internally sandal wood oil in capsules, each containing one-half gramme. If the patient is unable to swallow capsules, fifteen drops of the following is prescribed three times daily: Ol menthæ pip., gtt. x, ol. santali, ʒiv. By the use of sandal wood oil from fifteen to twenty per cent of all gonorrhœa cases are cured in one and one-half to three weeks. If at the end of three weeks the discharge has not disappeared, injections are resorted to. The best are sulphate of zinc, 1 to 200 and permanganate of potash, 1 to 2,000. Later astringents may be resorted to, such as tannic acid, 1 to 200, or nitrate of silver, 1 to 4,000. In cases of epididymitis, rest in bed and compress bandages are employed. In posterior urethritis and cystitis, for the purpose of relieving the dysuria, milk of almonds, salol, and a tea consisting of equal parts of linseed and uva ursi leaves are prescribed. In chronic gonorrhœa of the anterior urethra injections of silver nitrate, 1 to 2,000-500, are used. In chronic inflammation of the posterior urethra injections of silver nitrate by means of Guyon's

syringe, or ointments introduced by sounds, especially elastic bougies with olive pointed ends. After the sound has been anointed with a salve, consisting of nitrate of silver and yellow vaseline, āā three grammes, and lanolin, 44 grammes, it is dipped in liquid paraffin. Complete cure of a chronic urethritis is considered a rare event, and for this reason small threads (tripper, faden) frequently persist in the urine.—*Munchner Medicin. Wochenschr., Int. Jour. of Surgery.*

NEW OPERATION FOR BAD CLEFT PALATE.—Mr Arbuthnot Lane operated on a case of cleft palate by means of a method which he had adopted on a previous occasion. The child was two years of age. The upper lip, with the hard and soft palate, was cleft from before backward, and the cleft in the palate was of such a nature that it was hopeless to attempt to close it by any of the usual methods. On one side the palate terminated by an oblique junction with the lower end of the vomer, whilst on the other side there existed only the alveolus, which above was directly continuous with the inferior meatus of the nose. Mr. Lane removed the mucous membrane from the margin of the hard palate on the one side, and on the other he stripped the mucous membrane from the inferior turbinated bone and from the inferior meatus, and so formed a good sized flap of mucous tissue and periosteum whose base was continuous with the mucous membrane lining the inner asept of the aveolus which formed one boundary of the cleft. This flap was then made to cover in the cleft, being connected by a continuous suture with the opposing freshened edge. There was no possibility at the time of bringing the edges of the soft palate together, so this portion of the operation was postponed till the hard palate had developed a little. Nothing could have been more satisfactory than the result which was obtained from this method. Mr. Lane pointed out that it admitted of a tolerably wide application, though he had seen very few cases like the above in which it was so peculiarly applicable, and which were apparently not capable of being treated by the ordinary methods.—*Med. Press and Circular, Med. and Surg. Reporter.*

FOREIGN BODY IN THE RECTUM.—Lady, sixty-five years old, said she had suffered from piles for fifteen years, had tried many remedies all of which failed to relieve her. On inquiry she informed me that she had never had a rectal examination made. After some persuasion she consented to let me make a thorough examination. The finger was then introduced through the anus to the upper margin of the internal sphincter, where it came in contact with some hard substance which proved to be the forked portion of the breast bone of a chicken. I informed her that she would have to take an anæsthetic and have it removed, which was done by pushing it up. The two projecting portions of the bone were then seized, the ends pressed together, and the bone reversed. The two projecting portions had buried themselves deep into the tissues on either side of the bowel, and at these points the tissues were much indurated. This bone had probably been in the rectum for several years, since the patient did not have any recollection of ever having swallowed it. The after-treatment consisted in keeping the rectum clean, and the patient made a quick recovery.—*Gant in Medical Herald.*

VARICOSE ULCERS.—Dr. Reboul (*La Semaine Médicale*), treats various ulcers by cleansing, antisepsis and occlusion of the ulcer. He first applies gauze moistened with Van Swieten's solution, or a solution of the biniodide or cyanide of mercury, and covered with oiled silk. After four or five days of this treatment he finds the surface of the ulcer sufficiently modified and covered with granulations to proceed to the use of dry antiseptics. The ulcer is then filled with powdered salol and iodoform and over this salolized or iodoformized gauze is placed, then oiled silk and a tarlatan bandage, reaching from the ankle to the knee. This dressing is not changed for fifteen to twenty days, when the ulcer is found to have healed over completely. If not, a second, or possibly a third dressing may be requisite to complete the treatment. In cases where the infection is so ancient that mercurial solutions are insufficient to clean the ulcer, camphorated salol or camphorated naphthol may be necessary. He fills the cavity with gauze imbibed with these drugs and applies then an occlusive dressing.—*Med. and Surg. Reporter.*

TREATMENT OF GONORRHŒA.—W. S. James recommends the following injection, which, according to him, has given excellent results in a case of chronic gonorrhœa, where sulphate of zinc, nitrate of silver and bichloride of mercury had proved inefficient. He says that he has obtained equally favorable results from this composition in the acute form of this disease.

℞ Boracic acid, ʒ iss.
Tincture of iodine, ʒ ij.
Glycerine, ʒ j.
Distilled water, q. s. ad., ʒ iv.

To be used as an injection, morning and night.—*International Jour. of Surgery.*

CERTAIN PROBLEMS IN ABDOMINAL SURGERY; BASED ON ONE HUNDRED CŒLIOTOMIES.—The paper is an elaboration along the lines indicated in the following extracts:

The essentials of success in abdominal surgery are:

1. Early operation.
2. Careful preparation of the patient, with especial reference to stimulating the emunctories, and to securing asepsis of the abdominal wall.
3. An aseptic operating room.
4. Aseptic hands and instruments for the surgeon.
5. As great rapidity in operating as is compatible with careful, thorough work.
6. Irrigation and drainage in septic cases.
7. Careful after-treatment, embracing especially the withholding of fluids for about forty-eight hours, early purgation, and at least three weeks' confinement in bed.

Regarding the question of drainage, the author says that the better results obtained at present without drainage, as compared with the results of ten years ago, is explained by five facts:

1. Surgeons do cleaner work; they are more aseptic than formerly.
2. They have better means for securing hemostasis.
3. They do not use irritating chemical antiseptic solutions in the peritoneal cavity.
4. They deprive their patients of water for forty-eight hours after operation, thus producing systematic thirst, and bringing about the absorption of serum from the peritoneal cavity.

5. They purge early and freely on the first sign of peritoneal irritation.

He believes that the use of a drainage tube may cause hernia, and that it may prove an open door for infection. A carefully compiled table of cases closes this sensible article.—*Epitome of Med.; Am. Jour. Obstet.*

A New Method of Checking Bleeding After Tonsilotomy. — A year or so ago I read a paper written by Prof. Delavan, of this city, upon the subject of tonsilar hæmorrhages. In this article he has collected and discusses a very considerable number of expedients for governing the bleeding in this complication.

I was surprised not to find mentioned therein a method which I have taught my classes in operative surgery for several years past, and which seems unquestionably prompt, efficient, and easy of application; and is, furthermore, in my judgment, practically the best and wisest of the mechanical plans with which I am acquainted.

Although the expedient—which is presently to be explained—was of my own devising, yet it seems so self-evidently the thing to do that I took for granted the assumption that others must also have thought of the method and published it long ago.

Since reading Prof. Delavan's paper, however, I have made some inquiries, and not finding the plan mentioned in any book at hand, Dr. Otto J. Miller, of 206 East 104th Street, this city, has recently obliged me by spending a day in the Academy of Medicine Library, looking up this question in English, German, and French literature. He states that he finds no mention of the plan which I am about to detail.

Briefly, it consists in surrounding the bleeding surface with a stout purse-string ligature, of silk, or catgut, which when tightened is entirely hidden in the tissues about the tonsilar stump.

The surgeon selects a large needle, preferably semicircular in shape, and a needle-holder. The mouth is held open by a cork between the back teeth. Four stitches are now introduced. Less than two minutes is needed for this.

When the free ends are drawn upon, the loops of course disappear. The ligature is now tied tightly enough to stop bleeding, and the ends cut moderately short. The thread may either be left to slough out, or, and probably preferably, may be cut and removed in twenty-four to thirty-six hours.

As to the distance to which the needle penetrates, the two transverse strokes may enter to about one-quarter inch in depth. The two vertical ones, running parallel with the carotids, could, if desired, probably be passed with safety rather more deeply; though there would seem to be no special advantage in this.

It is not necessary to include the pillars of the fauces in the grasp of the thread. The two vertically placed stitches run, of course, very near the pillars, but not really in their substance.

Regarding the source of hæmorrhage after tonsilotomy, of one thing we can be certain, namely, that it never comes from either of the carotids. The external and internal carotids are very nearly equidistant from the tonsil, and behind it; the nearer, the internal, being rather more than half an inch away (1.5 ctm.); the external being, say, three-quarters of an inch (2 ctm.). If a tonsilotome be used, cutting either of these vessels is a mechanical impossibility.

At least six arteries supply the tonsil; all being branches, indirectly, of the external carotid. Of these the largest, as a rule, are from the ascending pharyngeal, and the ascending palatine.—*Dawbarn in Pacif. Record.*

The Treatment of Hæmorrhoids by Electricity. —Bacon employs the following methods, which in all of his cases caused a decided decrease in the tumors, without secondary hæmorrhage, sloughing or after-pains. He makes use of an instrument consisting of a long pair of forceps, similar to urethral forceps insulated with vulcanized rubber, except at a place one-half an inch in length on the face of the blades. By means of a binding screw the forceps can be connected with the positive pole of a battery. The hæmorrhoid is seized with the forceps in such a manner as to have the exposed metal of the blades clasp it at its base. The negative pole is connected with a disk or needle-holder, preferably one containing four needles. After grasping the hæmorrhoid with the forceps, a few drops of a four per cent solution of cocaine are injected into the tumor. The needles are then pushed into the center of the tumor, and a current of from five to ten milliamperes turned on. Immediately there will be noticed an escape of hydrogen about the needles, and a decided blanching of the pile. The current should be kept on until the tumor becomes a whitish gray, usually requiring from two to five minutes of time.

There are some points necessary to observe in using electrolysis in this class of cases: Thoroughly empty the colon before operating. Disinfect the tumor before introducing the needle. Never use this method in acutely inflamed hæmorrhoids. The needles should be boiled before using.—*Univ. Med. Mag.*

Therapeutics.

Certain New Methods of Treating Erysepelas. —The author (M. Cheron) briefly reviews some of the newer methods of treating this malady which have lately been put forth. Sachs recommends applications of ichthyol in collodion (10 per cent), painted on at least 2 cm. outside the limit of the disease. Luigi d'Amore applies terebinthine with a brush, and then covers the area with cotton. Casagaussi recommends bathing the part every three hours with a solution composed of one part each of tannin and camphor and eight parts of sulphuric ether. He also recommends one per cent solutions of fuchsin. Tichomiron uses iodine applications three or four times a day. Iodide of glycerin or iodized glycerin is of service for mucous surfaces. Bourbon employs aconite internally, one-tenth milligramme every two hours, not exceeding one milligramme in the course of the twenty-four. Halo has successfully prescribed pilocarpine in the erysipelas of children. Hacker has found satisfaction with hourly frictions of cocaine in oil of cacao. Foustanos has suggested the systematic employment of analgesin in erysipelas, and the external use of an ointment of phenic acid and finely powdered camphor in lanolin and vaselin.

Finally Guyot and Gaillard have employed corrosive sublimate in accordance with the following rules:

1. The remedy should be used in a one per cent ethereal solution.
2. A hard atomizer should be used of such device as to give a forcible spray.
3. Care should be taken to note the degree of sensitiveness in the skin and the extent of the skin infiltration.
4. Vesication of the skin by this method need cause no anxiety.
5. The applications should be extended about one centimeter outside of the affected area.
6. Care should be taken to apply the remedy very lightly over the tumefied upper eyelids, but the space between the eyelids and above and outside of the orbit should be very thoroughly heated so as to prevent, if possible, the spread of the infiltration up to the hairy scalp.
7. The face should be subsequently swathed in borated compresses.
8. One or two treatments suffice when they have been sufficiently thorough. Upon the neck, back, abdomen and extremities, the applications should be much longer than upon the face.

The collaborator believes that the sublimate method offers more promising results in the majority of cases than any other.—*La Tribune Médicale.—Med. Age.*

A New Treatment for Dysentery.—In the Texas Sanitarium, Dr. J. W. Mixon has been using a Mexican domestic remedy, *chopparro amargoso*, in his practice and on himself. He reports the following results:

1. In November, 1891, I had a protracted case of dysentery, complicated with an old fistula, which was operated upon and did nicely and soon healed, but the tenesmus and dysenteric stools continued. Commenced to drink a decoction of *chopparro amargoso* as an experiment, and continued it three or four times a day for three weeks, when I was entirely free from dysentery and able to ride horseback continuously.
2. Lately I had an attack of acute dysentery (for the first time since January, 1892); tenesmus, frequent stools, principally mucus mixed with blood.

Treatment.—Reduced daily fare one-half, and took 3j F. E. *amargoso* (or equivalent of decoction) three times a day. On the second day had the last stool of mucus tinged with blood; no more stools until the fourth day which was normal. Discontinued the *amargoso* on the fifth day; no symptoms up to now, two weeks since.

3. W. T. Magee, age fifty years, contracted acute dysentery in May, 1890; stools rather large; at first fecal matter and mucus tinged with blood, and frequent tenesmus, also fever. Was treated with aperients, small doses of calomel, oil, seidlitz powders, etc., followed by opium, astringents, bismuth, etc. In a month was able to ride out on horseback. From over-exercise in riding he relapsed, and was treated again, but ineffectually. The case became chronic; went through all known medical treatment as suggested by many different physicians; traveled for a change of climate, etc., with only temporary relief, gradually growing weaker and emaciated. In January, 1892, he commenced drinking a decoction of *chopparro amargoso* four or five times a day. He improved from the first; tenesmus less severe, stools nearer normal. In one month patient was almost entirely relieved. Has had only slight symptoms occasionally, which were at once relieved by a few draughts of amargoso.
4. R. T. Knox, M. D., of Gonzales, about sixty years old, general practitioner, is an enthusiast on the subject, from the remarkable cure of himself by this drug, after exhausting the pharmacopæia. Hearing of this Mexican remedy, he tried *chopparro amargoso*. The doctor writes me: "I had chronic dysentery for three years (May, 1889, to May, 1892). I used every known remedy for relief, but they only held the bowels in check for a short while. I tried this remedy and was much benefited. I will report my case in full soon."

He had grown so weak and emaciated that he had œdema of lower extremities, but now can be classed as a well man, notwithstanding the ravages produced by three years dysentery.

Ipecacuanha in Flatulent Dyspepsia.—Dr. Mathieu says, that ipecac is the best of the excito-moto remedies in this complaint. He gives the drug in powder, and in a compound tincture. The dose taken is two to ten centigrams (gr. ⅓ to 1⅔) of the powder, which may be mixed with bicarbonate of soda, colombo, and other correctives. If the tinctures are used, tincture of ipecacuanha is added to tincture of colombo and tincture of gentian. The first one, in France, is made one-fifth strength, so the dose is easy to calculate. It should be given after meals.—*American Therapist.*

Resorcin for Keloid.—Resorcin has lately been recommended for the treatment of keloid. It should be applied in combination with cacao butter, taking ten per cent of resorcin, and it is said that relief is complete and permanent. Resorcin is also used to detect disease of the cornea of the eye. One drop of a 10 to 20 per cent solution produces in the healthy eye a reddish coloration at once, which disappears with aid of a little water. If the cornea is affected, a more or less red color is imparted, which will persist for twenty minutes or so.—*American Therapist.*

Ice in a Phlegmasia Alba Dolens.—Dr. John A. Miller (*Pacific Med. Journal*), in treating on the subject of "milk leg," speaks highly of the efficacy of the cold treatment of the disease. He first used it in 1886, and since then has used it in six cases, with uniform and decided success. The procedure was in the following manner: An ordinary large towel was dipped into iced water, wrung out and clapped around the affected limb; a heavy flannel roller bandage was then applied from the toes upward to the groin. On the most painful parts, like the inner aspect of the thigh, the popliteal region and the calf of the leg, were laid rubber bags filled with ice. There were kept in place by a circular binder, independent and outside of the roller bandage. The patient was a little shocked when the cold towel was first applied, but the unpleasantness was only momentary, and then the reaction brought ease and comfort. She desired the ice bags to be renewed quite often at first, as she claimed they relieved the pain, as anything else had never done before. The pain was entirely controlled by the cold. The temperature dropped from 103° to 100° the next day,

and the patient commenced to improve, which continued uninterruptedly. The towel was freshly dipped from four to six times in the twenty-four hours. As soon as the patient experienced relief, she was quite anxious to endure the temporary chill from a fresh compress, because the limb felt always better for it afterward; the towels soon became dry and hot, and this gave rise to painful symptoms again.—*American Therapist.*

Analgesia by Hypodermic Injections of Cocaine. Dr. Thos. H. Manley, *American Therapist*, says: It may be safely employed in many cases in which pulmonary anesthetics are administered with danger to life; in conditions of shock, in organic disease, and in those who have a fear and horror of ether and chloroform. In many emergency cases in which one is called to operate late in the night, when skilled assistance is quite beyond convenient reach, or our patient is unable to meet the additional expense, it is without a rival, and will serve a thousand valuable purposes. But its administration must be intelligently supervised if we would derive the fullest benefits from it.

Here we must depart from the usual rules for hypodermatic medication. The part we propose to operate upon is sore, or hypersensitive. This must be benumbed before we take up the syringe. The point of the needle must be sent directly into the center of the diseased area which we propose to operate upon, so that the entire needle is lost to view. The solution which we propose to dislodge, must not be deposited in one place, but should be sprayed, according to the plan of Réclus (*Gaz. Hebdomidaire*, March 12, 1889). In my analgesic operations I use a one per cent solution of the hydrochlorate of cocaine, generally consuming about 75 to 100 drops in a protracted operation. A very large area may be sufficiently deadened with this dosage. In tumor operations four needle-punctures are made in such a manner as to outline a square. Now, the needle of a fully charged syringe is introduced deeply into the most sensitive part; and alternately with each puncture, after depositing five drops, when the needle is brought up to the integument, but not through, it is sent in again in a radial direction for six times, so that there are thirty separate injections made, but only four skin punctures.

I have recently, at the Harlem Hospital, by this plan, been able to effect the painless excision of the entire breast for epithelioma occurring in a young female. She would not take ether, because a year before her only sister had died on the operating table while undergoing anesthesia. With slight modifications this is the technique that I employ in all my rectal operations, and in cases for strangulated hernia.

It is well to know that there are some who, through some idiosyncracy, are extremely susceptible to the drug. Therefore one should always carefully note the effect upon the pulse and respiration after the *first* injection. As women are more sensitive to the drug than men, the dose for them must be smaller. It is not satisfactory in young children.

Papoid in Consumption.—Knowing the power of papoid to destroy germs and ulcers and on open surfaces, I have employed it in ozena, ulcers of the larnyx, and in ulcers and cavities in phthisis pulmonalis. I have used the drug, first by insufflation, but latterly by using the glycerole of papoid by the atomizer. Since the eight months of trial I have seen more and more convinced of its efficiency in the lesions named.

The treatment followed is:

First. Bromide of gold and arsenic internally, ten drops in water before meals.

Second. Depress the tongue that the spray of papoid may thoroughly reach all parts of the larnyx.

Third. Cause the patient to breathe deeply that the drug may reach all parts of the bronchioles.

Fourth. Employ the spray for at least ten minutes at each sitting.

Fifth. Use the spray morning and evening.

If there is no ulcer the papoid can do no good used as a spray. To obtain the best results the glycerole of papoid should be diluted with an equal amount of alcohol.

When papoid is used as a digestive ferment in cases of consumption where there is debility, weak digestion, and the suspicion of congested mucous patches, the drug should not be given in concentrated form, lest it dissolve the weakened tissues. In that case incorporate the papoid with the food before it is eaten. Sometimes it is better to partially prepeptonize the food.—*Wood in Med. Review.*

Carbolic Acid in Septicæmia.—Dr. Wiglesworth (*British Med. Jour.*) expresses a lively faith in the efficacy of carbolic acid in zymotic disease, given internally. He claims that if given in doses of four or five grains every two hours in the initial stage of puerperal septicæmia, it generally stamps it out in from twenty-four to thirty-six hours. In the latter stages of that disease combined with alternate doses of quinine, it is most effectual. In cases of apprehended puerperal septicæmia he commences its administration within twelve hours of completed labor with great success. His idea is to "carbolize" the patient, by giving a dose every two hours, night and day. When the urine has been rendered black by its administration, and kept so, the object is attained, for the urine thus altered may often be kept for weeks without decomposition taking place. This change in the color of the urine is not due from the presence of blood, for repeated examinations failed to detect a trace of blood even after the largest doses had been administered. The coloring matter has been found to be hydrochinon.—*Med. Review.*

Permanganate of Potash in Phosphorus Poisoning.—Dr. Erdös (*Norsk Magazin for Lævidenskaben*, No. 2, 1893), basing himself upon Antal's experiments upon dogs, has employed the antidote in the two following cases: A woman of twenty seven years, five months pregnant, soaked four packages of matches in water for six hours and drank the solution. At the writer's arrival she was unconscious and with a pale face, closed eyes, jerky breathing. Her pulse was full and regular. After an injection of half a syringeful of a one per cent solution of apomorphine she vomited a thick slimy mass, mixed with fragments of food, and smelling strongly of phosphorus. She then came to, refused to have her stomach washed out, but was persuaded to take a weak solution of the permanganate. Of this she took about one and a half litres in the course of an hour and a half, with violent vomiting between, yet she improved. The same day and the following night two more litres of the solution

were drunk, and the phosphorous odor disappeared from the vomit next day. She vomited some blood for two days, was weak, and complained of pains in her limbs and trembling. During this period the first movement of the fœtus were remarked. She improved rapidly and on the eighth day after the poisoning she could busy herself with light housework. As the amount taken was very large, and two hours had passed before treatment was instituted, the prognosis would have been regarded as unfavorable; and he ascribes the result to permanganate which solution should be drunk, and not introduced by means of the sound, and the mouth and œsophagus rinsed out with it.—*Lancet-Clinic.*

Treatment of Heat Stroke by Chloroform.—Koerfer (*Deutsche Med. Wochenschrift*, No. 28, 1893) reports the successful treatment of cases of severe heat stroke by means of chloroform. The terrible exhaustion incident to the severe convulsions of heat-stroke, is certainly no small factor in the fatal effect. Those who have watched cases of heat prostration treated with thorough application of cold baths and cardiac supportives, must have felt the incompleteness of the treatment, in seeing the continuance of the convulsions, even during the bath; and the great exhaustion of the heart following each seizure. As Koerfer points out, the circle is a vicious one; the overheated blood acts as an irritant to the cardiac ganglia and so causes excessive action of the heart's muscle, already weakened by the action of heated blood on its fibers. The same hot blood excites the nervous centers, raises the reflex irritability, while the resulting convulsions exhaust the nervous system and still further augment the heat production of the body. Cooling off the body, elimination of heat by baths, is of partial service only, if the over-production of heat is allowed to go on. This excessive formation of heat seems due largely to the over-irritated nervous centers, and it was for this reason that Koerfer treated his cases with chloroform inhalation. The patient, a soldier, had succumbed after a hard day of field practice, and presented a typical picture of severe thermic fever. The convulsions were severe, general and frequent, occurring on the slightest external irritation. There was increasing cyanosis, a very rapid, weak pulse, which failed almost entirely during the convulsion. Respiration was rapid and superficial. The convulsions, though still general, were becoming weaker, and in spite of baths and stimulants the patient was rapidly failing. At this point chloroform inhalation was tried in the hope of quieting the convulsions. The effect was immediate; after a few breaths the inspirations became deeper, the color improved and the tonic convulsions ceased. The heart's action in particular was improved, becoming steady, where it had been tumultuous, stronger, slower. At the end of an hour and a quarter the breathing was quiet and deep, the pulse regular at seventy, and the chloroform withdrawn and a small dose of morphia given subcutaneously. After a two hours' quiet sleep the patient woke conscious and convalescent. The after history of the case was not remarkable.

Another case gave the same happy result. It did not appear that the chloroform anæsthesia was more dangerous in the condition of sunstroke, than at other times, and the application of this remedy is certainly worthy of further trial.—*Boston Med. and Surg. Journal.*

Influence of Cold Baths Upon the Urine.—According to Winternitz, the quantity of toxines contained in the urine, in typhoid fever, is increased six or eight times by means of a cold bath, indicating that by the application of cold, in some way, there is an increased elimination of these poisonous matters from the body. This may possibly be connected with the fact that, as has been shown by Winternitz, the application of cold to the part results in an accumulation of leucocytes.—*Mod. Medical and Bact. World.*

Iodine in Typhoid Fever.—Considerable success has attended the treatment of patients suffering from typhoid fever with iodine in the practice of Dr. Klietsch, who reports in the *Münchener Medicinische Wochenschrift* that out of eighty-one cases treated in this manner only two died. The mixture prescribed consisted of: Iodide of potassium, from 90 to 120 grains; distilled water, 2½ drachms; peppermint water, 2½ drachms; solution of iodine, from 8 to 12 grains; from 8 to 10 drops to be taken every two hours. From four to six days after this treatment was commenced the temperature began to sink and grave cases became transformed into mild ones. As a rule defervescence occurred between the eighth and twelfth days; the condition of the bowels was very much better than under other forms of treatment. It was noticed that the appearance of the typhoid rash was exceptional. The theory of the method is that iodate of sodium is formed and that this is decomposed in the Peyer's patches, giving off nascent iodine, which is inimical to the development of the typhoid bacilli.—*Lancet.*

The Local Application of Petroleum in Diphtheria.—Flahaut in *Normandie Médicale.*—The writer reports an epidemic of diphtheria, affecting 70 persons, which prevailed in his town in 1891–1892. Between April 15th, 1891, and May 5th, 1892, thirty cases were treated in the usual method, with nine deaths. From May 5th to June 15th, 1892, forty cases were successfully treated by local applications of petroleum. This treatment which is so effective, is easy of application and devoid of danger and pain. At intervals of one or two hours, petroleum is painted over the false membranes, which quickly dissolve. Precautions are taken, of course, to prevent the fluid from falling into the trachea. These applications are painless, even when made on the ulcerated and bloody mucous membrane, and the liquid causes the pseudo-membrane to be dissolved.

Fifteen days after this treatment was applied to all the cases of diphtheria, the epidemic disappeared.—*Therapeutic Review.*

Treatment of Chloroform Narcosis.—Koenig of Goettingen, (*Lyon Médical, May 7th, 1893*). Out of seven thousand cases of chloroform anæsthesia, the author considers that he would have had several deaths, were it not for a method which was discovered accidently in his clinic. In the asphyxiated, it had been his custom to stimulate respiration by successive jerking compression on the left side of the thorax. In one case, the patient, a child, appeared to be dead; the cardiac action, the respiration and the hemorrhage at the site of the operation having ceased, the

jerking compression of the thorax was found useless, and the child, apparently dead, was taken into the adjourning room where one of the assistants continued the same treatment. The assistant, becoming impatient, struck the region of the heart with force, and the pulse was then felt synchronous with the blows, the skin became red, the pupils dilated and the respiration was re-established. When the blows were suspended, the signs of vitality disappeared again, but the treatment being continued the patient recovered finally. In other cases, this method was equally successful and the author thinks that it is worthy of being reported.

Notwithstanding these favorable results, it is our opinion that this treatment should be resorted to with caution. When the cardiac action is suspended, it may be well to excite the heart through the thoracic walls, but we should remember that forcible blows in the vicinity of the epigastric region may produce inhibitory effects on the respiratory and circulatory centers, which might prove irremediable.—*Therap. Review.*

Poisoning with Turpentine.—Carvete (*Canadian Practitioner*) has reported the case of a woman who at bedtime took half an ounce of old spirits of tupentine mixed with an ounce of whiskey, in mistake for castor oil. The mistake was only noticed after the turpentine had been swallowed, but nothing was done at the time except to take a dose of castor oil. The patient shortly afterward fell asleep, but was awakened in the course of five hours with sickness of the stomach. A little later she vomited, and after the lapse of several hours more she had a convulsion, followed by loss of consciousness. The pulse was weak, feeble, rapid; the face and lips pale; the patient restless, at times delirious and talking incoherently, but capable of being partly aroused. Urine had been passed in generous quantity. Whiskey, spirit of nitrous ether, milk and sweet oil were given, and warmth was applied to the body. Vomiting was induced by irritating the fauces. The vomited matters had a strong odor of turpentine ten hours after the fluid had been taken. After free vomiting, consciousness was regained and complaint was made of a burning pain in the right leg. Examination disclosed the presence upon the posterior aspect of the knee of a blister five by twelve inches in extent, the contents of which were watery and emitted an odor of turpentine. Gangrene of the superficial parts took place in this area, and fifteen weeks elapsed before the resulting ulcer healed.—*Med. and Surg. Reporter.*

Antipyretics.—1. That cold water is the best antipyretic used to-day.

2. That it is easily obtainable, and is therefore adapted to all classes of cases, both rich and poor.

3. The mode of application is so simple that it adapts itself to the hospital and equally as well to private practice, and can be applied without any distinct training.

4. Cautiously given, it stimulates.

5. Carelessly used, and longer than required, it depresses and will produce subnormal temperature.

6. That rectal temperature should be taken, and the bath at once discontinued when temperature falls to 101° F., as it will then continue to fall.

7. That a stimulant administered before the bath may be necessary, and should be given where there is a feeble heart.

8. That the temperature indicates when to commence and when also to discontinue the hydropathic treatment.

9. Unnecessary blanketing after the bath is injurious and will produce copious prespiration which, I believe, weakens the patient.

10. The temperature of the room should always be between 68° and 72° F.—*Dr. Fischer in Polyclinic.*

Diseases of Women.

The Binder in Childbed.—Windmüller (*Centralbl. f. Gynäk.* No. 27, 1893) recently opened a long and instructive discussion on the management of normal labor and childbed. He had conducted over a thousand labors in private practice alone in the course of thirty years. He wraps flannel round the body, but objects to the abdominal binder, which he finds interferes with the functions of the intestines, checks involution of the uterus, and is in the way during ablution. For the first three days he limits diet to milk, bread and butter, rice, spinach, potatoes and fish. He forbids wine and coffee, and believes, with Zweifel, that errors in diet are amongst the chief causes of prominent abdomen. The patient is kept on her back for three days, but Windmüller holds that ten days' rest in bed is sufficient. He has had no cases of prominent abdomen in any of his patients, even in multiparæ, with the exception of those who had grown fat. In the discussion several experienced obstetricians differed as to whether prominent abdomen was due to deposit of fat in the parietes after labor, or to distension of the intestines which could be controlled by the binder. Many surgeons applied no bandage after abdominal section; but the physiological conditions were then not the same as in the puerperium. Schrader and others believed that the binder did more good than harm; he laid great stress on diet in childbed as influencing the future form of the abdomen. All food liable to cause flatulence must be avoided; spinach and potatoes were particularly bad in this respect. When the pelvis was narrow, or its angle too acute, the chances of the abdomen becoming pendulous after labor were great. To counteract the evil a good abdominal binder should be worn during the last months of pregnancy. In Japan it was customary for women to wear a binder during the entire second half of gestation. The binder in pregnancy supported the anterior walls, and greatly diminished the chances of parting of the recti.—*British Med. Journal.—Lancet-Clinic.*

Eclampsia Gravidarium et Parturientium.—From an interesting and instructive paper with the above heading, which contains some original suggestions on this topic, by Dr. J. Lindsay Porteous (*Medical News*, Feb. 11, 1893), we have prepared the following diagrammatic illustration:

I. Hysterical.

Characterized by hysterical symptoms—globus.

II. Epileptic.

(a) *Premonitory*: Vague sensations; irascibility of temper; lowering of temperature from vascular contraction in extremities; spasmodic muscular contractions, optical illusions, hallucinations.

(b) *Paroxysmal:* (*Petit mal.*) Unconscious state; staring; contraction of facial muscles; movements as of swallowing; simply unconscious (Reynolds); loss of perception and volition.

(*Haut mal.*)—Face-pallor; loss of consciousness; cerebral and spinal congestion; laryngismus and trachelismus; peculiar cry; tonic muscular contractions (extremities); visceral contractions (bowels, womb, bladder, etc.); cyanosis, coma; fatigue, headache, sleep; albuminous urine.

(c) *Inter-paroxysmal:* Impaired nutrition, excitable; loss of memory, melancholia; disordered digestion and circulation (not necessary concomitants, or peculiar to epilepsy).

III. Uremic.

Due to non-elimination; mechanical (?) chemical (?)

IV. Apoplectic.

Urine diminished, highly albuminous; general convulsions at outset; coma develops slowly; sudden onset; face flushed; increased arterial tension; embarrassment of respiration; coma sudden, with dilatation of pupils; relaxation of sphincters; unilateral paralysis; subnormal temperature followed by rise.

V. Microbic.

Caused by a microörganism, (first announced March 25, 1892). Absence of the other characteristic symptoms.—*American Therapist.*

Sugar in the Urine of Pregnant, Lying-in, and Nursing Women.— L. J. Berberoff, basing himself upon investigations—unfortunately not sufficiently numerous—concludes that lactine only appears in the urine when more milk than is necessary is secreted by the gland. It therefore appears in the urine from the third to the fifth day, when the function of the gland and its production increase, while the infant still requires but little milk. On the other hand, however greatly the mammæ may be developed, when the child sucks out the milk entirely—*i. e.*, when the equilibrium of production and consumption is kept up—no sugar is to be found in the urine. When, on the contrary, there exist conditions in connection with moderately developed mammæ tending to arrest the production of milk in them, sugar appears in the urine. Among these conditions must be included changes in the mammary gland through which sucking is arrested, cracked nipples, mastitis, etc. In fact, sugar was most frequently found by him in parturient women suffering from these disorders.—*Vratch, Univ. Med. Journal.*

Obstetrics.

Fetal Placental Circulation During Parturition.—Caviglia (*Nouvelle Archives d'Obstétrique et de Gynécologie*, December, 1892, January and February, 1893) after a series of careful observations, has arrived at the following conclusions:

(1). Blood passes from the placenta to the child during the process of birth, through the uterine pressure, retraction and sometimes contraction.

(2). The constant positive pressure of the fetal vena cava superior forms a resistance opposed to the passage of placental blood by the fetal organism. This resistance is inferior, however, to the force acting upon the placenta, and is not sufficient to prevent the afflux of blood.

(3). Respiration takes away cardiac force and blood from the systemic circulation, hence it diminishes venous pressure and the special resistance referred to in the second conclusion.

(4). The afflux exists but to a slight extent in cyanotic asphixia, owing to the high blood-pressure in the venous system of the child.

(5). The arrest of the fetal-placental circulation does not depend upon the diminution of pressure in the fetal arterial system, but on the occlusion of the placental capilliaries by uterine pressure. When the placenta is expelled early, the pulsations may continue almost indefinitely.

(6). The passage of blood from the placenta to the new-born child often continues after the umbilical arteries have ceased to pulsate.

(7). During the first moments after birth the child's weight occasionally diminishes, on account of relaxation of the uterus. Too early ligature, therefore, involves the risk of removing from the child's circulation not only all the reserve blood, but also some of the blood necessary for the child at any given moment.

The last two conclusions are important in practical obstetrics.—*Union Med. Magazine.*

Spontaneous Rupture of the Symphysis Pubis During Labor.—Oelschlager (*Centralbl. fur Gynakol*) has reported the case of a primipara, twenty years old, in which with the onset of labor pains two eclamptic attacks occurred in quick succession. The lower extremities were edematous, and the urine contained a small amount of albumin. The promontory of the sacrum could be touched with two fingers introduced into the vagina. The head was quite high in the pelvis and but slowly followed in the grasp of the forceps, a not excessive degree of traction being exercised. As the head began to rotate in the small pelvis a crack was distinctly heard. Examination disclosed a separation of 1.15 inches in the situation of the symphysis pubis, and the delivery of a living child weighing nine pounds was soon readily effected. On the day following the labor, a leather support was applied to the hips. For two weeks the region of the symphysis was tender upon touch and painful upon movement, but a week later the woman was able to be up and about, although a slight degree of separation of the pubic bones persisted.—*Med. and Surg. Reporter.*

The Dangers in Antiseptic Midwifery.—Schräder (*Centralblatt f. Gynäk.* No. 16, 1893) has called attention to the exceptions in the success of antiseptic obstetrical practice, and endeavors to explain the cause, why the practice is not universally successful. He holds that the poison of puerperal endometritis is often actually diffused throughout the body by intrauterine irrigations, thus causing a local and probably a harmless morbid condition to become the agent of deadly infection, the veins and lymphatics acting as the diffusers. The stimulation of the uterine muscular tissue by the injections increases the lymphatic absorption. Although vaginal injections are much safer, he believes that they frequently cause a general infection. The fact that a streptococcus has been found to be normally present in the vaginal secretions after labor by Doderlin, is considered of importance. Schräder strongly condemns the use of caustics in puerperal ulcers. The reason for the rapid heal-

ing of a lacerated perineum when it is repaired immediately after labor is that the parts are allowed to rest. Glöckner's statistics are not favorable to prophylactic irrigation.—*Medical and Surgical Reporter.*

THE INFLUENCE OF CHLOROFORM UPON THE COURSE OF NORMAL LABOR, AS SHOWN BY THE TACHADYNEMOMETER.—Donhoff (*Archiv. für Gynakologie*), administered chloroform in various degrees to five cases of normal labor, and noticed its influence upon the expulsive force of the uterus and abdominal muscles, as shown by a carefully constructed physiological apparatus. The conclusions reached are in substance the following:

1. The administration of chloroform, even in diminutive doses, exercises a retarding influence upon the progress of labor. The muscular pressure sinks to one-half of the amount of that present before the administration of the anæsthetic. In eight observations the average figures were 1,837.

2. The expulsive force of the uterine contractions steadily diminishes during the exhibition of chloroform.

4. The labor pains, besides being weaker, are also more irregular during slight anæsthesia. During deep anæsthesia the intervals between the pains are longer, and all the pains are diminished in strength.

4. The pains increase immediately after discontinuing the anæsthetic. The expulsive force of the contractions after stopping the chloroform, compared with the force just before its administration, is, as expressed in figures, 2–3.

5. The labor pains generally continue diminished in power for some time after discontinuing the chloroform. In one case they had resumed their normal intensity in ten minutes, while in two other cases two hours had expired.

6. If the action of the abdominal muscles is only slight, this action is checked entirely by a superficial anæsthesia, but soon reappears after the stopping of the chloroform.

7. The action of the abdominal muscles continues, but in diminished force, during superficial anæsthesia, if before the exhibition of the chloroform it was vigorous in character.

8. Deep anæsthesia abolishes entirely the action of the voluntary muscles.

9. The intervals between the pains become longer immediately after chloroform is administered, and the labor pains besides being less intense, decrease in numbers about twenty-five per cent.

These carefully conducted experiments show that chloroform, no matter in what degree it is administered, exercises a retarding influence upon the progress of labor. The expulsive forces are lessened, and there is no corresponding diminution of the resistance.—*Abstract.*

TREATMENT OF POST-PARTUM HÆMORRHAGE.—Dr. Ernest Herman, obstetric physician to the London Hospital, has published a paper on this subject. He says that in the treatment of post-partum hæmorrhage nothing can be relied upon that does not ensure compression of the bleeding vessels. The chief precautions against the prevention of hæmorrhage are care not to extract child or placenta when the uterus is not contracting, and close supervision of the third stage of labor. The post-partum hæmorrhage under discussion is the common kind, namely, that due to uterine atony. The modes of stopping bleeding after labor may be divided into three groups, according to their principal aims, which are: 1st, to make the uterus contract; 2d, to compress the bleeding veins; 3d, to clot the blood.

There are three ways of making the uterus contract, namely: direct stimulation, indirect stimulation, and drug stimulation. Direct stimulation, such as kneading with the hand outside, is almost always successful for the time, and in the slighter cases its repetition at intervals is enough. The second step is to pass the hand into the relaxed uterus. Not only does this stimulate the uterus, but by it we gain help in diagnosis and prevention. The business of the intra-uterine hand is to find out if there be anything in the womb which is causing bleeding; and, if there be, to remove it. Injection of hot water provokes contraction and does good by washing out loose clots, etc. Water in which the accoucheur can bear to immerse his hand will not injure the tissues. Cold water, or ice, or electricity may also be used. Reflex stimulation may suffice, through the nerves of the skin, by applying ice or cold to the vulva or abdomen, or of the breast by putting the child to the bosom. Drug stimulation is represented by one drug—the only one which produces uterine contraction and retraction—namely, ergot. Its chief uses are as a prophylactic, given immediately after the birth of the child; and after bleeding has stopped, to make tonic the contraction produced by other means. As regards the treatment of exhaustion of contractile power—the worst cases in these—pressure, or blood clotting, or a combination of both, must be relied on. The injection of perchloride of iron stimulates the uterus to contract and clots the blood. The objections to this treatment are: first, that it is dangerous; and secondly, that it is not always successful.

Plugging the uterus with iodoform gauze, the new German treatment, may be dangerous; sudden death has taken place from the entrance of air into a uterine vein while the gauze was being put in. Continuous compression is the best and only remedy when the contractile power of the uterus is exhausted. There are various methods of employing it. The right way is to compress the uterus between one hand in the vagina and the other on the abdomen. The best way is to bend the fingers of the left hand into the palm, and grasp the uterine body between the right hand on the abdominal wall and the firm resisting surface formed by the closed fingers and volar prominences of the left hand in the vagina.—*Brit. Med. Jour.—Ont. Med. Journal.*

Toxicology.

METHOD OF DEATH BY CHLOROFORM, ETHER.—In the *Medical and Surgical Reporter* Dr. William Cheatam of Louisville thus gives the relative dangers of ether and chloroform: As to the method of death he believes the rule is that patients dying from chloroform anæsthesia die suddenly and there is no time to make an effort at resuscitation. The two facts that we do have deaths from chloroform in the hands of careful, experienced men, and that such deaths are generally sudden, is against its administration. On the other side, you take ether in the hands of a man who is accustomed to giving it, and if there is any trouble from

its administration it comes on in such a manner as to give a man time to make an effort to save his patient. Some years ago Dr. Cheatam gave ether for a gentleman in New York, and the patient came near dying three days afterward from kidney complication. He was taken sick immediately after the administration of ether and was in a serious condition for three days, then made a good recovery. With chloroform, should there have been trouble, death would likely have come suddenly and there would have been no time to make an effort to save the patient. In view of these facts the author thinks ether the safest anæsthetic of the two. In the city of Louisville within the last year there have been six deaths from chloroform, all of them occurring before any instrument was used, while preparations were being made for the operation. Some years ago Dr. Cheatam saw in the city hospital a man who had taken chloroform eighteen times before for the same trouble (dislocated shoulder) and the nineteenth time he died; death was sudden after taking only a few whiffs of chloroform.—*Nat. Med. Review.*

Poisoning by Codeine.—Dr. Spratling cites a case where a young married woman had taken sixteen half-grain pills. She had suffered for months from a painful disease, and was instructed by her physician to take codeine in quarter-grain doses for the relief of pain and to overcome a persistent insomnia. Not deeming the amount sufficient, she of her own accord increased the dose to eight grains to allay the pain (so she stated) three hours before Dr. Spratling was called. An hour later she experienced considerable nausea, and vomited a small quantity of semi-liquid matter. He found her awake and able to converse perfectly well, but very restless, tossing from one side of the bed to the other. Occasionally she would have convulsive movements involving the entire voluntary muscular system, but more marked in the upper extremities and head. There was intense irritation of the skin, but was most annoying over the flexor surface of the forearms and on the back. The skin was warm and dry. The pupils were fixed in pin-point contraction. Respirations were twelve per minute. Complained of intense thirst and feeling of fullness in the head. She did not experience any of the pleasant mental effects that follow the exhibition of morphine, but stated that her "thoughts were going round and round." After sponging thebody with solution of bicarbonate of soda she sank into a light dose, for which she would awake every few minutes with a start. She was subjected to the usual treatment for opium poisoning, and in a few hours was much improved. By noon the following day she had fully recovered, except there was considerable muscular weakness.—*N. Y. Med. Rec.—Epitome.*

Diseases of Children.

A Case of Scarlatinal Recrudescence.—On May 27th, J. M., æt. 5 years, presented all the initial symptoms of an attack of scarlet fever. Her temperature suddenly rose to 101°. Had complete loss of appetite, with vomiting. On the following day the rash presented itself. It appeared first upon the neck and chest, and gradually spread and covered the whole body in twenty-four hours. Patient was transferred to the isolation ward, where the disease ran the course of a typical case of scarlet fever. Temperature gradually subsided, with daily remissions, as the rash disappeared, becoming normal on third day. Desquamation commenced about the usual time, but at no time was it very marked.

On July 3d, while still isolated, the child became irritable, complained of headache, vomited, refused to take any nourishment; while the tongue presented the characteristic strawberry appearance. Temperature rose to 100°, with considerable angina present.

On the 4th a rash appeared, similar in every respect to that of the previous attack. To-day (the fifth day since the rash appeared) the temperature has reached normal line, and desquamation is commencing.—*Canad. Practitioner.*

Pulmonary Diseases of Children.—In the *So. Cal. Practitioner*, Dr. I. B. Gregory discusses this subject and suggests the following points in medication:

1. Avoid opiates except in the first stage of pleurisy and croupous pneumonia, and in the delirium of the latter try codeine alone or in combination with antikamnia.
2. Avoid nauseant or depressing agents except a little ipecac or phenacetine in cases where they are especially indicated, and turpeth mineral to produce vomiting.
3. Limit the use of aconite and veratrum to the beginning of croupous pneumonia.
4. Use the ammonia salts, particularly the carbonate, freely, combining them with iodide of potassium in bronchitis.

A mixture containing two grains of the carbonate, or a grain each of carbonate and muriate to a drachm of syrup of acacia will cause no gastric irritation.

5. Use alcohol boldly, strychnia and belladonna carefully, in addition to the ammonia mixture, when there is a tendency to collapse, particularly in acute bronchitis and broncho-pneumonia when the skin is pallid, temperature moderate or low, and inspiration labored.
6. Pilocarpine is worthy of trial in the first stage of croupous pneumonia.
7. Quinine can be administered to infants by combining it with dilute sulphuric acid and glycerine and applying it to the skin, by suppository, or in a mixture with a solution of solid glycyrrhiza and syrup.
8. During convalescence, syrup of hypophosphites and syrup of hydriodic acid are indicated. Iodide of potassium may be substituted for the latter when it is not well borne and where the diet consists chiefly of milk.

Book Reviews.

"Stricture of the Urethra." By G. Frank Lydston, M. D., Professor of Genito-Urinary Surgery and Syphilis Chicago College of Physicians and Surgeons; Attending Surgeon Cook County Hospital.

This work is a complete presentation of the modern views of urethral stricture held by American surgeons, and contains the results of the author's extensive experience in urethral surgery. The book contains numerous illustrations, and is decidedly creditable to the W. T. Keener Co., of Chicago, which is largely engaged in publishing medical works by western authors. It is to be hoped that the western

profession will give this enterprising firm the encouragement it deserves.

Items.

CRAMPS OF CHOLERA.—

℞ Chloral hydrate.....℥iij
Morphia sulph.....gr. j
Atropia sulph.....gr. ¼
Aq. chloroformi, } āā ℥ ss
Aq. destil., }

Sig.: Twenty minims, repeated in ten minutes, and then as needed.

—*Bartholow, in Medical Record,*

LOCAL ANÆSTHESIA FOR MINOR OPERATIONS.—

	Parts.
Menthol.....	1
Ether.....	15
Chloroform.....	100

Use in spray apparatus.

—*Dobisch, in Medical Record.*

NUMBER OF BEDS IN THE HOSPITALS OF DIFFERENT CITIES.—New York, 11,000; Brooklyn, 2,000; Philadelphia, 6,391; Cincinnati, 3,000; Buffalo, 1,025; Albany, 447; St. Louis, 2,086; St. Joseph, 849; Kansas City, 516; Omaha, 617; Detroit, 762; Milwaukee, 667; Chicago, 4,684; Denver, 961; St. Paul, 522; Minneapolis, 325.

THE DANGER LINE IN ANÆSTHESIA.—From the Reports of the Clinical Society of Louisville, as published in a recent number of the *Medical and Surgical Reporter*, we glean the following interesting statements. Dr. Kynett, of Philadelphia, called attention to this valuable sign as the danger line in anæsthesia; when the addition of fresh ether to the cone fails to produce an up-and-down movement of the wind-pipe the ether should be withdrawn; when that movement occurs, the condition is a safe one.—*National Medical Review.*

THE AMERICAN MEDICAL EDITORS will have a meeting and banquet in Washington on the evening of Monday, September 4th, the day preceding the assembling of the Pan-American Medical Congress. Dr. I. N. Love, of the *Medical Mirror*, 3642 Lindell Avenue, St. Louis, has been appointed Chairman of the Committee of Arrangements for Banquet, which fact gives ample assurance of the success of the latter. It is earnestly hoped that every medical editor of all the Americas will endeavor to be present on the interesting occasion. Please address the Chairman of Committee on Arrangements promptly.

DESTRUCTION OF MICROBES BY INFUSORIA.—D. Harvey Atfield (*British Medical Journal*), a student in the Hygienic Institute of the University of Munich, recently carried out a number of experiments at the suggestion of Dr. Emmerich, for the purpose of determining whether microbes of polluted river water are destroyed by infusoria. The experiment shows very clearly that the low forms of animal life which abound in river water are exceedingly active in the destruction of bacteria, and hence of service in the purification of water. In one instance, water which contained 3,000,000 bacteria per cubic centimeter (¼ drachm)was found to contain at the end of ten days after infusoria was introduced, only 13,000 bacteria, a proportionate decrease of 200 to 1. In another case the decrease was 500 to 1. In another case of water placed under the same conditions, without the infusoria, the number of bacteria increased from 700 per cubic centimeter to 121,500.—*Mod. Med. and Bact. World.*

IRON AS A HEMOSTATIC.—Prof. Cheever, of Harvard University, recommends ferric alum as a styptic, on account of its nonirritating properties. It coagulates the blood very quickly, and forms with the clot a sort of sand which is not irritating to the tissues, while persulphate and perchloride of iron form hard, brittle angular clots.

RECTAL CATARRH.—Dr. Strizovere reports "that chronic rectal catarrh can be promptly relieved by irrigating the rectum with a solution of carbolic acid, in the proportion of one-half drachm to a pint of warm water; this to be repeated morning and evening, being retained about ten minutes each time. Within a few days decided improvement is noticed, and cures have been reported where the disease was of many months' duration."

COCAINE IN INFANTILE DIARRHEAS.—Dr. Williams in the *Medical Tribune*, says: "The past two years I have made a great deal of use of muriate of cocaine one-sixtieth of a grain, in diseases of infants. In very advanced cases of cholera infantum I find that it not only relieves the pain and soreness, but also strengthens the heart against collapse, and prevents the tendency to exhaustive vomit. Used in connection with salol and bismuth it helps to disinfect and quiet the intestinal excitement."

CHLOROFORM AS A HEMOSTATIC.—A writer in the *Med. Press* recommends the use of chloroform as a general hemostatic. Applied on lint or absorbent cotton to the bleeding surface, it promptly stays the flow, acts as a direct stimulant to the patient, and leaves no blood crust to fall off and recommence the bleeding.

CALOMEL FOR GOUT.—A writer in the *Deutsche Med. Wochenschr.* reports that he has successfully treated acute and subacute gout by means of calomel, administered in a large single dose. The result he ascribes to the stimulation of peristaltic activity, as it is known that an attack of gout is often preceded by intestinal torpor.—*Notes on New Remedies.*

Wit and Humor.

First Quack: Here is a letter it would hardly do for us to publish. A man writes: "I have just taken my first bottle of your medicine, and I—"

Second Quack: Well?

First Quack: There it breaks off short, and is signed in another handwriting, "per executor."—*Brooklyn Life.*

The Cut Direct.

"For years he was well known to me,"
So the physician sadly said,
"But now, called to his autopsy,
I am obliged to cut him dead."

—*Brooklyn Life.*

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ORIGINAL ARTICLES.

Remarks on Urethral Strictures of Large Caliber, with Illustrative Cases.*

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It may have seemed to the members of this society on reading the title of the present paper, that the author had selected a theme that had been worn threadbare. I believe, however, that there is still much to be said upon the subject of urethral strictures of large caliber in their direct and remote relations to genito-urinary pathology. I find with increasing experience that the views of Otis and his school become more and more worthy of consideration. Despite the value of the teaching of Otis, the majority of practitioners have apparently failed to profit by it. Hardly a day passes but some neglected case of gleet or reflex urinary disturbance incidental to the lesions under consideration comes under my personal observation. The necessity of a careful study of strictures of large caliber should on all occasions be impressed upon the mind of the practitioner. When such cases are thoroughly understood, the andrologist will be relieved of some of the embarrassing features of daily practice. It is by no means a pleasant thing, after one has made a diagnosis of stricture of large caliber, and suggested urethrotomy for the purpose of relieving direct or reflex symptoms dependent upon said stricture, to have the patient seek other advice, fall into the hands of a man who diagnosticates stricture by means of an ordinary urethral sound, and perhaps a dirty one at that, and be informed that an operation is entirely unnecessary, and was undoubtedly proposed by the specialist for the sake of a fee. Such an experience is by no means uncommon. The imputation of diagnostic inaccuracy is in itself a very disagreeable result of the prevailing ignorance upon this subject. I firmly believe, however, that the ultra-conservative views of the honest and capable men among the opponents of the theories of Dr. Otis—said opponents having been in many instances men of high standing—has had much to do with such sources of embarrassment. A certain number of practitioners have been inclined to accept without qualification Dr. Otis' views of the acquired pathological character of strictures of large caliber in the pendulous urethra. Others, following the dicta of Sands, Weir and others, have held with equal vehemence that all of the strictures of large caliber described by Otis are normal contractions which are to be found in every urethra. Both of the warring factions have forgotten the main point at issue when a case of urethral stricture of large caliber confronts us. The question in any case of gleet, prostatic or vesical irritation, urethral or testicular neuralgia, associated with contractions in the urethral canal, is not whether the said contractions were primarily normal, or have been acquired through chronic inflammation; the question to be decided simply is: What is the relation of these coarctations to the indubitable pathological conditions and symptomatic manifestations presented by the particular case in hand? My own experience has led me to believe that there is no point in genito-urinary pathology as important as the consideration of this question. I meet with cases in which intractable gleets have been treated for months and months, though they had not been supposed to depend upon stricture of the urethra, because, forsooth, the surgeon in attendance has repeatedly succeeded in passing a sound of quite large caliber into the bladder. Careful exploration, nevertheless, determines in a large proportion of such cases the existence of tender, perhaps granular, coarctations. Division of these strictures of large caliber results in a cure of the gleet, the relation between cause and effect being so clearly demonstrable that he who runs may read. In other instances I have met with patients who had been treated for years for alleged obstinate inflammation of the prostate, irritability of the vesical neck, inflammation of the bladder, or some one or more of the other multitudinous effects which may occur, as a consequence of direct or reflex irritation from urethral stricture. In cases of this kind the more the prostate and bladder are treated, the worse the case becomes, and the patient can never be put on the road to a cure until a thorough division of the point of contracture has been made. Very often the point of contracture is apparent rather than real, consisting only in normal inelasticity or indistensibility at some point in the canal. This I freely admit, but these points of inelasticity and indistensibility may none the less produce irritation and imperfect drainage of the urethra. This is very easily illustrated by the alternate passage of a sound and a bulbous bougie, the sound passes by the obstruction without any difficulty, while the bulb of relatively much smaller size requires some force for its passage. The coarctation yields readily to the pressure of the sound, which uniformly distends the urethra anterior to it, and possibly has more or less of a sedative effect upon the mucous membrane, yet the bulb finds the stricture in the exact condition in which it remains during the interval of exploration. The bulb finds the stricture in precisely the same condition as the contraction which presents itself to the outflow of urine during micturition. Outflowing urine produces friction just as surely as does the exploring bulb in passing over the contracted point. This point of inelasticity may be congenital or acquired; the result is the same. If it is acquired, its pathological character is beyond dispute, but in the larger proportion of cases I know of no way to prove that the coarctation is acquired rather than congenital. If we explore a patient who has never had urethral disease or injury, and we find these coarctations, the inference is obvious if the history be accurate. The probabilities are, that many of the so-called strictures of large caliber are normal, and of congenital origin; but the relation of such strictures of large caliber to the healthy urethra is very different from that which they bear to a urethra in a condition of disease. The inflamed urethra is necessarily more or less narrowed

*Chicago Medical Society, August, 1893.

in its lumen. Micturition goes on the same as in health, with the exception perhaps that in many instances the frequency of the acts of micturition is increased; the hydrostatic pressure of the urine being the same and the caliber of the urethra diminished, it is obvious that increased friction occurs at given points of inelasticity or contraction. This friction produces a condition of unrest, which is inimical to proper repair, and it is such points that perpetuate a gleety discharge; such points also very often form the fons et origo mali of vesical and prostatic irritation, or of neuralgia in various situations, especially in the vicinity of the genital organs. To consider the question of the normal or acquired origin of such points of friction or irritation is, it seems to me, to put it mildly, very absurd. It is probable that there are competent men in this society who would be inclined to dispute this proposition. If any such are present, I trust that they will vigorously dispute it in the discussion of this point, so that the questions at issue may be fairly presented to the general practitioners present. At this juncture I will reiterate a proposition already laid down, that the question at issue in cases of this kind simply is: what is the possible or probable relation of the tender and contracted point in the urethra to the symptoms manifested by the patient, whether these symptoms be reflex or direct? I desire also to state in positive terms my opinion that no case of urethral disease of long-standing and obstinate character; no case of urethralgia or neuralgia of the testicle; no case of vesical or prostatic disturbance has been done full justice until all points of possible local and reflex irritation in the form of strictures of large caliber in the pendulous urethra have been subtracted from the pathological sum total by urethrotomy. I shall not consider the question of the permanent character of the results obtained by urethrotomy in this paper; I will simply state that in my opinion, when the operation is properly done, the result is usually not only satisfactory, but likely to be permanent. We will suppose, however, for the sake of argument, that the result is not permanent, but that some years later on, coarctations may still be detected by careful exploration with the exploratory bulbs. If the immediate result of the operation is a cure of the conditions for which the patient consults us, the possible return of the coarctations later in life is of little consequence as bearing upon the success of the operation. Once the urethra becomes healthy, points of coarctation or inelasticity of congenital origin bear the same relation to the urethra that they did before the patient ever contracted a venereal disease. If, therefore, the operation is immediately successful, the result will be permanent, providing the patient does not again contract a gonorrhœa. I believe that we should regard all of the cases of stricture of large caliber as primarily congenital, inasmuch as it is probable that points of normal inelasticity or contraction are the foundation for the majority of cases of stricture, whether of large or small caliber.

I trust that in the discussion of this paper due attention will be paid to the point which I will now take the liberty to make, namely, that an exploration of the urethra by means of the ordinary sound is so inaccurate and unreliable as to be practically worthless for diagnostic purposes. I wish to insist that any opinion upon the existence or nonexistence of stricture of the urethra as a possible or probable cause for the perpetuation of gleet, prostatic and vesical irritation, is practically worthless if based upon exploration with the sound. The fact that the sound which has been used is of large size does not, it seems to me, negative the truth of this proposition. The time of this society is entirely too valuable for me to present a long array of cases, which I believe to be confirmatory of the decided position assumed in the remarks which have been made. I will therefore ask your indulgence in permitting me to report a few typically illustrative cases.

CASE I. Neuralgia of the urethra, testes, and spermatic cords with prostatic irritation, due to stricture of large caliber. Patient, a married man, 31 years of age, presented himself to me with a gleet of three years' standing. For one year prior to consulting me he had been affected with severe shooting pains in the spermatic cord, testes and urethra. Micturition was attended by severe burning and cutting pain which lasted for some little time after the act was completed. The venereal orgasm was painful, followed frequently by severe throbbing in the perineum. Micturition was quite frequent, the patient being compelled to rise several times at night. There were frequent exacerbations of urethral discharge, due to the usual causes of sexual indulgence and dietetic excesses. Examination with the urethrometer showed a linear contraction in the pendulous urethra at the peno-scrotal angle. This admitted a No. 30 French sound with very little difficulty. On expanding the urethrometer to a caliber of 24 French, a distinct coarctation could be detected. This was excessively tender and bled readily under the pressure of the urethrometer. The meatus showed a caliber of 32 French. Urethrotomy was advised and consented to. At the present time, two months since the operation, the neuralgic manisestations and prostatic irritation have entirely subfided. The urethra, however, is still somewhat tender and the discharge, although frequent and watery, has not entirely disappeared.

CASE II. Prostatic irritation due to stricture of large caliber. A gentleman, 35 years of age, was referred to me by Dr. W. P. Verity, of Chicago, for treatment of what was supposed to be a prostatic or prostato-vesical trouble. The surgeon who had treated the case prior to his coming under Dr. Verity's observation, had cut the meatus, and as nearly as the patient could describe it, a stricture of two inches within that orifice. This surgeon—a very competent man—had had the patient under observation for two years, during which time the symptoms referable to the prostate and bladder had been annoying. The slight gleety discharge was still perceptible. Examination showed a urethra which was normally quite large, the normal caliber being 36 French. Examination with bulb showed the meatus which would admit of No. 30 with difficulty. At a depth of two inches a coarctation measuring 26 was found, and at the peno-scrotal angle a third point of narrowing, which would admit only a 24 bulb, was detected. The entire urethra was exquisitely tender, the tenderness being especially manifest at the points of narrowing. A 30 sound was passed with very little difficulty. An operation was suggested, and an appointment made for its performance. In the meantime the patient met his former surgeon and told him what I proposed to do. That gentleman said that he did not see what there was to cut in

the patient's urethra. The following day I received a letter from the surgeon, asking me what I could find in that particular part to operate upon. The operation was performed, the urethra cut to its full normal caliber, and the case within three months was practically well.

CASE III. Prostatic irritation due to stricture of large caliber. A gentleman, aged forty, had been affected for the past ten years with frequent micturition, and had been variously treated for prostatic and bladder disease. There was the usual history of gonorrhœa in his younger days. Examination showed a contracted meatus and two strictures of a caliber respectively of twenty and twenty-five French, located very close together at a depth of three inches and a half. The normal caliber was approximately thirty French. Urethrotomy was performed with almost immediate relief of the symptoms. For several months after the operation however some prostatic irritation remained. The patient was assured that this would eventually disappear, and the accuracy of this opinion was verified by a recent examination of the patient who stated that he was no longer compelled to rise at night to urinate, and could get along very comfortably by urinating three or four times daily. He assured me that his general health had greatly improved, and that he was pretty well satisfied with his semi-occasional acts of micturition, inasmuch as he had become habituated to rising from six to ten times at night to micturate. He also remarked that if I knew of any doctors or patients who did not believe in strictures of large caliber he would be pleased to make an attempt at their conversion.

CASE IV. Atony of the bladder due to stricture of large caliber in the pendulous urethra. The patient, a man about forty years of age, came to me complaining of lack of power to expel his urine. He stated that while his stream of urine was apparently amply large, it flowed very slowly, and he was compelled to make considerable effort with the abdominal muscles in order to empty the bladder. He had had a gonorrhœa many years before, but as he had been very rapidly cured, he had no notion that it bore any relation to his present trouble. There had been no gleet and never any frequency of micturition. A loss of sexual power was complained of, the patient stating that the orgasm was neither as forcible nor as pleasurable as formerly. Examination revealed a moderately contracted meatus, which admitted an eighteen bulb. At a depth of two inches and a half in the pendulous urethra a tender point of contraction was found, the caliber of which was twenty-three French. The remainder of the canal was apparently in a normal condition. Passage of a catheter revealed marked vesical atony. Urethrotomy was performed with immediate improvement in the symptoms. This improvement, however, was slight at first, but progressively increased. It was six months before the patient reported himself as practically as strong as regards the function of micturition as he ever was in his life. His sexual power was also perfectly restored. As the condition for which he was operated on had lasted for several years before I saw the patient, the relation of cause and effect would seem to be very well established. Cases of this kind are by no means frequent. Reflex spasmodic contraction of the bladder is quite commonly seen in such cases. Reflex inhibition of the innerving fibers of the bladder is quite exceptionally seen.

CASE V. Urethrorrhagia due to stricture of large caliber. The patient was referred to me by Dr. J. G. Berry, of Chicago. There was the usual history of gonorrhœa some years before, which was supposed to have been thoroughly cured. For some months the patient had a very peculiar experience during coitus, the act being attended by urethral hæmorrhage, which became very profuse during the orgasm and lasted for some time afterward. So profuse was the discharge at times that the female side of the venereal experience would think that she had suddenly begun to menstruate. Examination detected a stricture of a caliber of twenty-six French at a depth of four and a half inches from the meatus. This stricture was linear and exquisitely tender, exploration setting up quite profuse hæmorrhage. Urethrotomy was proposed, but was not performed because the patient could not conveniently submit to it. Dilatation has therefore been practiced, and although the stricture has been dilated only four or five times, the symptom for which the patient consulted me has entirely disappeared, and the patient states that the genital organs feel much better generally. It might be remarked in the consideration of this case that urethrorrhagia independent of traumatism is not a very frequent condition. I shall take the opportunity at some future time of discussing this case in extenso. It would seem that there exist at the site of the stricture in such cases, vascular granulations which bleed at the slightest touch of the instrument or may give rise to hæmorrhage under the circumstances described in this case. In some instances even the passage of urine will give rise to this symptom. To illustrate the rarity of such cases of urethrorrhagia, however, I will state that our prominent authorities have paid very little attention to it. Guyon has failed to call attention to urethral hæmorrhage as an important symptom of stricture. Inan elaborate article on Urethral Pathology by Messrs. Denos and Kirmisson in the Dictionary of the Medical Sciences, edited by Dechambre, no mention is made of urethrorrhagia in the symptomatology of urethral stricture.

CASE VI. Prostatic and vesical irritation due to stricture of large caliber. The patient, a physician, 60 years of age, was referred to me by Professors Jos. Zeisler and Wm. E. Morgan, of Chicago, for electro-endoscopic examination. Stricture of the urethra was not suspected as the patient had had in times past a very large sound passed into the bladder. He had been treated for prostatic and vesical trouble for fifteen years. He had no distinct recollection of any venereal disease or traumatism. The doctor had been treated by some very eminent men, among whom was a gentleman of New York City, who has never been quite in accord with the views of Dr. Otis. The patient was also under the charge at one time of Dr. Gross the elder. As he expressed it, he had had posterior urethral injections and urethral dilatation ad nauseam, and that the more he was treated the worse he seemed to get. Examination showed a urethra of an approximately normal caliber of 38 French. At a depth of four inches an irritable and resilient stricture of a caliber of 34 French was found. Lest the pathological nature of this coarctation be disputed on account of extreme size, I must state that the shoulder of the bulb passed through the point of narrowing, and in the withdrawal of the instrument there was a distinct

snap that was audible not only to myself but to the two competent physicians present. The abrupt passage of the bulb over the point of coarctation was only too painfully evident to the patient himself, who immediately exclaimed, "That is the point where my trouble lies, and I know it." Electro-endoscopic examination of the urethra showed a congested and granular condition below the point of coarctation, the morbid appearance being especially marked in the bulbous urethra. Urethrotomy was suggested and taken under advisement by the patient and his medical attendants. The slight stretching incidental to the passage of the bulb produced such marked benefit in the old gentleman's condition that he wished to be operated upon the very next day. Indeed, he waited rather impatiently for the time of operation to arrive, which was set for three days later. The operation was performed and with the most satisfactory results. After the division of the stricture it was found that a 35 sound could be passed with very little difficulty into the membranous and prostatic portions of the canal without producing any marked pain. Exploration prior to the division of the stricture had been usually quite painful, even with sounds of moderate size. Since the operation the patient has reported himself as greatly improved, and on the high road to recovery.*

I will not attempt to impose further cases upon the society, although I have a large number of typically illustrative ones at my command. I think that those which have been described will prove sufficiently suggestive to bring out a thorough discussion of the subject. I have purposely omitted all description of cases of strictures of large caliber, the only manifestation of which is the existence of an obstinate gleet. I believe, however, that such cases are too often passed unrecognized. If urethrotomy were more frequently performed, it is my candid opinion there would be fewer cases of uncured gleet going the rounds and less excuse for the fault finding prevalent among both physicians and patients regarding the curability of gonorrhœa. I am well aware of the important relations which posterior urethritis bears to those various conditions that are so frequently associated with chronic urethral and prostatic disease. I believe, however, that the importance of many of the cases of posterior urethritis that we meet is over-estimated, and that in some of them an obstinate gleet is perpetuated not by the posterior urethritis, but by strictures of large caliber in the anterior urethra. Granting that posterior urethritis is the cause of quite a proportion of cases of gleet and chronic gonorrhœa I still believe that we cannot do the case full justice until we have subtracted all possible causes of direct and reflex irritation in the anterior urethra. The sooner the practitioner recognizes the fact that a very large proportion of cases of so-called inflammation of the vesical neck, neuralgia of the vesical neck, prostatitis, posterior urethritis, etc., etc., are reflex effects produced by strictures of large caliber in the anterior portion of the canal, the better it will be for our patients, and the more creditable to the surgeon will be our results.

Opera House Block.

*I have just received a letter from the doctor, who expresses great satisfaction at his present condition.

Some Abuses in the Use of Ergot.

By Louis Becker, M. D., Knoxville, Ill.

Read before the Military Tract Medical Association at Canton, Ill., Oct. 18th, 1892.

At the last annual meeting of our society a discussion arose as to the propriety of the use of ergot during the course of labor. The position I took at that time, I could see, was decidedly with the minority, and in fact one of my best friends in the profession advised me against bringing up such a discussion, anen because the practice of using ergot was settled upon the profession that it was useless to complain and one was sure of being "sat down upon" for his pains. Nevertheless my opinions are very decided on this subject, formed I hope after due reading and reflection, and if the society wishes a victim I am all the more useful for that purpose as I am in fairly good flesh.

We can proceed logically by inquiring first, what are the physiological actions of ergot. From that and the practical experience of nearly a century we can deduce. Second, the action of ergot under pathological conditions. Under this head we can argue the use of ergot during labor for I suppose no one would advocate its use in any but pathological conditions.

Ergot was introduced to the American profession in 1807 and on account of its power of strengthening uterine contractions it was called *pulvis ad partum*. Not a great while afterward on account of the mortality, especially with children, to which its reckless use gave rise, Dr. Hosack suggested that it be renamed *pulvis ad mortem*—a neat turn of the phrase with much more truth than is usual in such attempts.

Physiological Action.—Ergot slows the heart beat and causes a considerable rise in blood pressure. The slow beat is probably due to its effect on the nerve ganglia of the heart, while the increased blood pressure is caused by stimulating the vaso-motor center and causing contraction of the arterioles (H. C. Wood). Its action on the unstriped muscle of the uterus is, according to many eminent observers, a direct stimulation; according to others equally eminent it is due to arterial anæma which is well known to be a cause of such contractions. This difference of opinion, however, affects its clinical use very slightly. It is the universal testimony of our best observers that small doses increase the length and force of uterine contractions, at the same time changing their character somewhat. Large doses bring on more continuous but less rythmical contractions which finally become one prolonged tetanic spasm. Some observers deny, others affirm, its power of *orginating* uterine contractions *de novo*.

Pathological Uses of Ergot in the First Stage of Labor.—Let us see first what is the general opinion of therapeutists and obstetricians in regard to this. Bartholow (Materia Medica and Therapeutics) says: "If ergot is given during the first stage, disastrous consequences may ensue to both mother and child.

On the part of the mother, the violent and continuous pains—the resistance in front remaining—may rupture the womb, lacerate the cervix, etc. On the part of the child it arrests hæmatosis by direct action on the placental blood, and partly by continuous compression of the fœtal body—but the chief danger is paralysis of the fœtal heart."

H. C. Wood (Materia Medica and Therapeutics), says: "Never give ergot in the first stage of labor." He gives practically the same reasons as Bartholow for this statement. Lusk (Science and Art of Midwifery, page 454), says: "Of the various internal remedies to stimulate uterine action, ergot should, in the first stage of labor, be unqualifiedly prohibited."

Parvin (Obstetrics, page 444), says simply, but positively: "Ergot is not to be given in the first stage of labor."

Schroeder (Obstetrics, last German edition), uses even stronger language in prohibiting its use, as we shall see farther on. Martin and Spiegelberg, in Germany, Engleman, Jaggard, Hyde, Jewett, Grandin, etc., use language of equal positiveness.

From such an array of eminent therapeutists and obstetricians there is no appeal and we must conclude that in the opinion of those best qualified by experience to judge, ergot should be unqualifiedly rejected in the first stage of labor. How universal is it the case that when the pains are light and the first stage is delayed or those distressing "nagging" pains come on, that we fly at once to the ergot bottle without regard for the condition of the patient! And in how large a percentage of such cases do we presently see those intense, unending tetanic pains come on, the patient shrieking in agony until we are obliged to use chloroform and very possibly the forceps to undo the mischief a small amount of medicine has done. Afterward this same patient does service as one of our prize "hard cases" and we get and appropriate to ourselves a great deal of credit where we deserve the utmost condemnation. Why not be honest about the matter and place the blame where it belongs—on our own shoulders? This is one of the very ordinary cases for often more serious results follow. The os contracts and becomes hard; the tissues, from the unceasing pressure become swollen and hot; the child's head is covered with an immense *caput succedaneum*; its life, always endangered by the pressure, is often altogether sacrificed, and finally a ruptured uterus and two deaths stares us in the face everytime we pick up the ergot bottle in such a case. Truly a skull and cross-bones is the proper label on such a bottle carried in our obstetric bag. There might in many cases be an excuse for running such a risk if we had no other means at our disposal, but the fact is we have many. Among the simpler are, the erect position; hot teas or hot lemonade; hot vaginal injections; faradism when a battery is within reach; rubbing over the fundus of the uterus which is very affective. Among medicines Fordyce Barker and Albert H. Smith in this country are authorities for the use of quinine. The latter says that in every one of forty-two women to whom he gave fifteen grains of quinine in the first stage of labor he noticed a decided increase in force but no change in the character of the pains within fifteen minutes. For the "nagging" pains we have morphine and chloral, especially the latter. Time and again have I noticed after its use a period of quiet rest and then a beginning of regular, forceful, rythmical contractions. But often, as all who have used it much will testify, the character of the pains is immediately changed to the natural and one is often accused of using the so-called "forcing medicine." Then we have as valuable and sure agents Bramis Colpeurynter, Barnes' bags, and in rare cases the forceps. Taken all in all such an array of means and methods at our disposal leaves little to be desired.

Ergot then should be rejected in the first stage, because first, according to the universal testimony of our best authorities it does perceptible harm in the vast majority of cases and is easily capable of destroying the life of both mother and child. Second: because we cannot select our cases with a knowledge of which will be hurt and which not. Third: because it does not fulfil the indications since it entirely changes the character of the contractions in every case in which enough is used to be of effect. Fourth: because we have an array of agents much more effective and much less dangerous.

Should ergot be used in the uterine inertia of the second stage? Let us see again what the authorities say. Bartholow rejects ergot in the second stage except when all the parts are easily dilatable and relaxed, as he believes that a ruptured perineum, etc., is frequently the result of its use. H. C. Wood (loc. cit.), says the considerations of the danger to both mother and child "are, I think, sufficient without further discussion, to show the imperativeness of the rule *never* to give ergot in uterine inertia when there is much resistance either in the bony or the soft parts of the mother. In primipara such resistance is always to be looked for and its degree often difficult to judge of beforehand; and in such women ergot should not be used at all for purposes of expulsion. Even under the most favorable circumstances for its employment, when the woman has previously borne children, when the bony pelvis is capacious and the soft parts are relaxed and dilatable, its use should be entered upon with caution; and if the accoucheur be skillful in the application of instruments, cases must be rare in which the latter are not preferable to the ecbolic." A statement such as the above, to my mind, is about equivalent to an entire rejection of the drug. Parvin puts about the same restrictions around its use as Wood. Lusk says: "We should also abstain from the use of ergot in the second stage, unless it seems necessary as a prophylactic against post-partum hæmorrhage." And again he says, as between ergot and the forceps "the advantages of safety and celerity are all on the side of the forceps."

George J. Engleman, of St. Louis (Pepper's System of Medicine, Vol. IV., page 512), says: "I have insisted that this drug must not be given in labors or abortions until the contents of the uterine cavity have been removed."

Schroeder (loc. cit.), says: "Notwithstanding the well-known effect ergot has of strengthening the uterine contractions, it is decided to reject it entirely until the uterine cavity is emptied." He then goes on to show the dangers to both mother and child as already given, and the other better means we have for the same purpose. Martin and Spiegelberg, two German authorities of vast experience, have thrown the weight of their authority toward the entire rejection of ergot in labor.

J. W. Hyde quoted in Annual Universal Medical Sciences (1889), says: "Ergot given prior to delivery gives a frightful mortality among children, and is the most frequent cause of retention of the placenta. He adds that it has been condemned by most of the maternities of Europe and America *in toto*.

Chas. Jewett quoted in the same work makes an equally strong protest against using it before labor is complete. Benicke records twenty-seven cases in

which ergot was given in the uterine inertia of the second stage, in which spontaneous delivery occurred in seven only. In a discussion before the British Medical Association, 1890, led by the eminent obstetrician, Playfair, ergot was mentioned once so far as the reports give the truth. Dr. Playfair in discussing just this condition of uterine inertia, mentioned quinine, morphine, and especially chloral, hot water, friction, expression, etc., but did not speak of ergot at all. In the subsequent discussion participated in by many eminent men, ergot was mentioned by but one, Dr. More Madden. He says that in such cases, he gives at once half an ounce of the fluid extract. This rather startling dose is explained in the next sentence when he affirms that he believes in "meddlesome midwifery."

An examination of the above evidence shows that the rejection of ergot while less vehement than in the first stage is none the less positive, for the restrictions placed about its use by those few who allow it at all are so many, and of such a character, that its use must be very rare, as it is practically confined to the rare cases of suspected post-partum hæmorrhage, and is then given at the last of the stage.

We must conclude then that ergot is not to be used in the second stage. First, because it is dangerous to both mother and child for the same reasons as in the first stage. Second, because we have more certain and less dangerous means at hand, such as friction over the fundus, various means of expression, chloral, opium, quinine, and above all in this stage the forceps, infinitely superior to ergot, both as regards efficiency and safety.

The Third Stage.—A few writers as Bartholow speak of giving ergot as a routine practice when the head is on the perineum to ward off a possible post-partum hæmorrhage. But the head is so often delayed a short time in just that place, thus making us liable to get the effect of the ergot before the child is born, and causing a ruptured perineum, and there is so much liability to a retained placenta from hour-glass contraction that the profit realized is surely not worth the risk. In cases where we have reason to suspect a severe post-partum hæmorrhage, such a risk is justifiably taken, perhaps, although even here, as Lusk says, it may be preferable to have a hypodermic of ergot ready at hand to give at the instant of completion of the third stage, controlling the uterus with the hand while awaiting its effects. Almost all the writers quoted above take this view rather than the one given by Bartholow. We are so easily able to complete the third stage by Crede's method of expression of the placenta, that the factor of uterine inertia hardly demands attention.

I have consulted all the authorities at my hand without selection and they are all men to whose opinion on such a subject we are accustomed to attach importance. They have decided unanimously against the use of ergot in the first stage. With one exception they have practically decided against its use in the second stage. They are almost unanimous against its use in the third stage except as a prophylactic against suspected severe post-partum hæmorrhage.

In the presence of such a conclusion as this what is our duty as a profession? Manifestly it can be nothing less than a refusal to use the drug in these prohibited cases. On scarcely another important obstetric problem do we find such unanimity among those best able to judge. Even in the realm of vaccination for prevention of small pox we as a profession are not so unanimous. I have no terms too strong in which to deprecate its use. As Engleman says, "it would be better far to do without it than to continue the prevalent abuse." What a condemnation is ours then, when, because of the solicitations of friends, or because of our haste to get through, or a neglect to use other and better remedies, we subject a mother and her unborn child to such dangers as have been pointed, out while knowing we are acting just contrary to the recorded opinion of our profession. To my mind it is a fearful thing to think of, that this is taking place every day; that the doctor who boasts of rarely having to stay more than hour at an obstetric case is abroad in the land.

If I have succeeded in placing some of the abuses in the application of a very useful drug in a clearer light I shall be satisfied. I have said very little about my own experience, for none of us, unless we have had very exceptional facilities, are justified in trying to decide such a question for ourselves. What little experience I have had in my own practice, and especially as a consultant, coincides exactly with the views I have expressed above. Twice I have yielded to the solicitations of friends and have used ergot improperly. Just that often have I had bitter cause to rue it, and I lay the agony of two mothers to my want of decision, and I have not yet stopped thanking my stars that more serious results did not occur. We must stop trying to blind ourselves to the facts of such cases, and must be ready to admit that the intense pains and the more severe accidents, even to rupture of the uterus, coming on after our use of ergot, are not the result of natural causes, but are the direct result of the ergot we have given; and that we are directly and almost criminally responsible for every such accident in the light of the knowledge of to-day.

Some Remarks on Urinary Calculi.

By M. M. Hooton, M. D.

Delivered before the Military Tract Medical Association at Canton, Illinois, October 19, 1892.

Mr. President, and Members of the Association: The object of this paper is not so much to contribute anything new to what is already known of urinary calculi, as to elicit if possible some elucidation of problemswhich to my mind seem to be very vaguely comprehended by us.

As a foundation, therefore, to what I may say, I will cite two cases for our consideration.

A few years ago my attention was called to the case of Mr. B., who was afflicted with a disorder of the urinary organs which necessitated the constant use of the catheter whenever his urine was to be evacuated. I found the left side of his heart very much hypertrophied, and extensive valvular insufficiency, with all the ordinary symptoms of this condition existing in an aggravated form. The excretion of urine was apparently normal in quantity, but extremely painful. Specific gravity ranged from 1.008 to 1.028, and on being discharged quickly deposited a sediment of what seemed to be an impalpable reddish brown powder. But under a small microscope showed distinct crystalline formation. Analysis showed a small quantity of albumin, and considerable

sugar. The history of this case showed an existence of nine or ten years with periods of relaxation and exacerbation of variable length. But the attending physician informed me that for the greater part of the time the deposit of this powder or sand was present. About eight months after I saw him first, his symptoms became much aggravated and death soon came to his relief. At the post-mortem the prostate gland was found to be about the size of a goose egg. So large indeed as to be almost unrecognizable.

The left kidney was atrophied to one-half its normal size and so granular as to be easily broken in pieces with the fingers. The right kidney was slightly contracted, tough and elastic, with the feeling of rubber, and on being cut into, was found almost as blue as indigo. No gravel was found either in the kidneys or bladder. Stomach, lungs and bowels normal.

The heart weighed twenty nine ounces. The walls of the left ventricle were three-fourths of an inch thick. The walls of the right ventricle and both auricles were much thinner than normal and expanded to quite double the normal capacity. The pulmonary artery and norta were in an unurismal condition, so that the valves were entirely insufficient to completely close the orifices of either of these two vessels.

Case 2, was Mr. A. My attention was called to him about four years ago. He indured intense suffering on micturition, but otherwise was apparently in good health. There was no tenderness or pain in the region of the kidneys at any time during life. On examination of his urine I found apparently the same impalpable powder as in the former case, which, however, was not constant. The suffering did not abate when the powder or sand disappeared. There was a small quantity of albumin at times, but no more than could be accounted for as coming from a small amount of pus which I found in the urine.

I examined for stone carefully with the sound and per rectum, and discovered nothing. This patient was examined by several other physicians about this time, but all agreed that there was no gravel. The stomach, heart and lungs were in splendid condition, as were also the intestines.

I irrigated the bladder with the double catheter a number of times and he became better apparently and went to work in a butcher's shop, where he remained for two or three months, and was then treated by a neighboring physician without success, and again came to me. I then attempted to introduce the sound to determine if I could find a stone. I could not get rid of the impression that there must be gravel in this case. On attempting to introduce the sound I found some little difficulty at the neck of the bladder, but nothing that could not have been overcome had it not been for the intense pain the instrument caused.

I then tried to anæsthetize the sensitive part with cocaine hydrochlorate.

This, to my surprise, was a failure. I threw into the bubous urethra a ten per cent solution repeatedly, with no apparent abatement of the sensitiveness of the part. I then made another examination per rectum, and found nothing. I still insisted upon an examination with the sound, but my patient absolutely rebelled, and I abandoned the case, my medicines having failed to give any permanent relief. This was about two years ago. He then called another physician, but would not permit an examination with the sound. After about a year he came back to me, begging me to try once more to give him some relief from the agony he was suffering. At this time there appeared an elongated elastic tumor in the left iliac fossa, extending about four inches above the pubis and about two inches in diameter, extending nearly in a line with the ureter. This would appear and disappear synchronously with the suffering, and I concluded it must be caused by accumulations of urine. But what part of the urinary canal was it in? It was too far to the left, and too high up for the bladder. Could it be an enormously expanded ureter plugged up at its entrance into the bladder by a renal calculus?

About this time I was beginning to be considerably mystified. I had long ago abandoned all hope of giving permanent relief without an operation for stone or some other growth that at times obstructed the flow of urine which was always intensely painful and tedious.

I now made as careful an examination externally as I could, and told this patient that he could make his choice between death and an operation.

An operation was positively refused, and after several months of intense suffering dysentery supervened and death soon followed.

I have said that there never was the least tenderness or pain in the region of the kidneys up to the time of his death. There was some tenderness over the bladder a few months before death. There was a slight increase in the amount of pus in his urine. The entire suffering was in the region of the neck of the bladder.

After death I made a post-mortem examination and found both kidneys shrunken to little more than half the normal size, and literally a mass of small abscesses. These pockets ranged from the size of a pin head to that of a large pea, and were filled with a white, creamy pus. The left kidney was found four and a half inches below, and to the right of its normal position and floated loosely among the intestines. The spleen was much shortened and somewhat granular.

The tumor which we had felt in the left iliac fossa proved to be the bladder, which was elongated to a considerable extent, and the left lateral support was so shortened as to draw it far too high to be reached by the finger in the rectum. The bladder was slightly constricted in the middle, and in the lower part of its cavity we found the stone which I here show you. (The stone was here exhibited, weighing at the time of its extraction 1.180 grains.) The bladder was contracted transversely to such an extent as to grasp the stone closely, but there was no evidence of ulceration of the bladder, and nothing that would seem to account for the intense sensitiveness of the neck when an attempt was made to introduce the sound.

The walls of the bladder were much thickened on the left side and lower part, and considerable adhesions of connective tissue. There was not the slightest difficulty in introducing the sound—after death—which readily revealed the existence of a stone of considerable size. The left ureter, as you can see by the specimen on the table, is slightly enlarged, and exhibits some evidences of disorganization.

The left kidney, as you will observe, is much smaller than the right, and much changed in some parts of its structure.

The practical lessons to be deduced from the cases above cited involves a discussion of three questions,

First. Was the disease of the kindeys the cause of the stone, or the stone the cause of the kidney disease? Or was either of them primary?

Second. If the solution of the case is not found in either of the above queries, what then was the primary cause of both kidney disease and the formation of the stone?

Third. How are we to explain the extreme sensitiveness of the neck of the bladder in the second case and intense pain in the stomach in the first case?

The discussion of the first and third questions seems to be so involved that it is difficult to separate them.

The extreme tenderness and pain was present long before any stone could be discovered. The fine powder was present in each of the two cases. But in number one no pain of account was felt in the bladder and the patient used the catheter himself for eight years without difficulty. In the latter case (No. 2) the pain in the bladder was the first symptom of disease.

It is admitted that a small concretion may have existed in the bladder at the time of our examination three years ago and being deeply covered with mucus escaped our notice.

If we assume that there was the nucleus of a stone in the bladder prior to the existence of pain, we are only involving ourselves in another mystery. What then was the cause of the stone? It may be said the diseased kidneys sent down more of the salts and earthy matters than healthy urine could hold in solution and hence the deposit. This answer is just as satisfactory as was the answer to the question, what supports the earth? The answer was it rests on a great turtle. But no one could tell what the turtle stood on.

It is very difficult to understand how even a diseased kidney could separate such an unusual amount of salts of which such stones are generally formed, from healthy blood.

It would therefore seem quite probable that the primary cause lay farther back, and that the digestive organs were responsible to a great extent for the unusual deposit. This being so the unusual supply of abnormal material to be handled by the kidneys would soon develop in them disease of some kind.

But here we have two cases in which the urine is substantially of the same composition. They both show the same pulverulent, precipitate and mucopurulent deposit. But the resultant disease of the kidneys is radically different. The first case complained of constant pain in the stomach, but that organ was found apparently sound. The second suffered intense pain at the neck of the bladder but that organ as well as the prostate was found apparently normal, or nearly so. In view of these facts I am constrained to believe that the severe pain in both cases was reflex neuralgia. Exactly how this was effected I will not attempt to explain.

It may be somewhat hazardous for me to assume in view of all the facts here stated, that I believe the primary cause lies in imperfect digestion or assimilation, or both, and the failure of other organs like the liver and skin to perform their functions sufficiently vigorous, thus throwing upon the kidneys the duty of eliminating a large amount of salts, more than normal.

It would appear, therefore, that any treatment to be successful must be addressed largely to the digestive organs and emunctories of the system other than the kidneys and bladder. But in this case, No. 2, if an operation for the removal of the stone had been successfully performed, could it have saved his life? In view of the diseased condition of his kidneys, I know of no treatment that holds out much hope of cure.

In looking over such text-books as I have in my office, I find that writers generally touch upon the etiology of urinary calculi with extreme caution. And as to treatment, their prescriptions mainly refer to modes of getting rid of the stone. Acids and alkalies are the remedies. After a somewhat extended experience, I have come to the conclusion that any attempt to secure the action of any acid or alkali on a stone in the bladder or pelvis of the kidney, will prove a failure. And the evidences of such a result in the experience of writers, is based on a bad diagnosis. The best treatment in my judgment is that which will restore and keep the digestive organs and the skin in a healthy condition, and the removal of the stone when formed.

But my paper is already longer than I intended, and I will not enter on the details of treatments.

Influence of Cold Baths on the Urine.—According to Winternitz, the quantity of toxines contained in the urine in typhoid fever is increased six or eight times by means of a cold bath; indicating that by the application of cold, in some way, there is an increased elimination of these poisonous matters from the body. This may possibly be connected with the fact that, as has been shown by Winternitz, the application of cold to the part results in an accumulation of leucocytes.—*Jour. of Baln.*

Illumination of the Eyes from Behind.—When an incandescent lamp is introduced into the mouth, for the purpose of ascertaining, by trans-illumination, the condition of the maxillary antra, the pupils are seen as blood-red apertures. Mr. N. Stevenson calls attention to the curious fact that when the light is thus introduced, as it were, by a back door, the pupils do not contract. This observation may prove to possess considerable importance.—*Medical Press.*

Infanticide.—A singular method of infanticide was reported at a meeting of the Paris Medico-Legal Society. An infant of five months died without having shown any symptoms of previous disease. Nevertheless, suspicion was aroused, and the body exhumed some sixteen months after burial. No traces of poison were discovered, but the intestines were found to contain some eight pieces of a blackish grey substance which completely blocked the passage. Careful examination showed that these pieces were sponge, and Professor Caseneuve gave it as his opinion that they were administered to the child for the purpose of killing it. This opinion was founded partly upon the fact that the pieces of sponge presented a cut surface, and also upon the knowledge that in certain parts of the country the custom prevails of killing stray dogs by placing in their way pieces of sponge soaked in grease, which when swallowed, swell up inside of the intestines, and so cause death. The jury accepted this view and brought in a verdict of guilty.—*N. W. Lancet.*

Western Medical Reporter.

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Medical Education.

Writers on this subject devote no end of space to showing the ill effects of defective education in students but, as a rule, devote little attention to deficiencies in professors. No school will ever have students of higher grade than it demands, for the law of supply and demand is as strong here as in the world of trade. Ill-educated professors will not attract well educated classes. Dr. A. Jacobi, at the last annual dinner of the Harvard Medical Alumni Association, described aptly how professional chairs are filled.

He said: "There are many ways of becoming or appointing professors, some of which are as follows: Thirty years ago I was offered the place of professor of diseases of children. I replied I could not think of accepting, I did not know enough. My friend who was a professor and knew all about it, laughed, and replied, if he were offered a chair of nautics, he would begin lecturing to-morrow. That is, gentlemen, how I became professor of pediatrics, only because there was no place vacant for a Columbus. Others are cousins, friends, assistants in private practice. To be rich, well connected, and have relatives among hospital and college trustees is a very good mental equipment. Have a friend who is wealthy and endows a chair for you. In Germany, be a son-in-law of a leading professor. But lately I read of the death of a German *Privatdocent*, at the ripe age of seventy-four, whom I knew when he was already *Privatdocent*, but proved his incapacity for advancement by refusing to marry the daughter of the full chair. Write a text-book while you are young and fresh. There are so many that you can extract half a dozen, and make the seventh with the aid of very little brains and much more posteriora. Operate on two alleged lacerations daily, and let no more than fifty per cent die of septicæmia. Prove that the best place for ovaries is in a jar. Render yourself a parody of the great Philadelphian who makes a diagnosis before he cuts babies' skulls, by sawing without diagnosis. The first is seen and heard and heard of; the latter is not. On that line there are many possibilities."

C. C. P. SILVA, M. D.

C. C. P. Silva, M. D.

C. C. P. Silva, M. D., was born in the city of Funchal, the capital of the Archipelago of Maderia Islands, on the 24th day of August, 1841.

In due time he was sent to a private school, noted not only for the masterly manner in which instruction was imparted to the pupils, but also for its strict discipline.

At the termination of his course, provided with a certificate of approval of his examinations, he entered The National Lyceum, of Funchal, an institution under the auspices of the government, devoted to the teaching of humanities, where a select corps of faithful and competent professors dedicate their whole lifetime to the instruction of the youth.

After his final examination at the Lyceum, he matriculated in The Medico Chirurgico School of Funchal, a college also maintained and controlled by the government, requiring a course of four years before the admission for final examinations for a diploma. His turn for graduation came at the closing of the fourth year, and he left his alma mater with a full stock of high aspiration in the mind, and a sheepskin under the arm.

Soon after he received the double appointment of interne to The Mercy Hospital, the best in the island, where all the poor throughout the Archipelago call for help, and assistant interne to The Hospice Dona Maria Amelia, exclusively for the treatment of consumptives, founded and royally equipped by the Empress of Brazil, in memory of her daughter who died of the same disease.

At the end of two years he resigned these positions and served a short term as attending physician to the Hospital de Sao Lazaro, solely devoted to the care of the lepers who, coming from all parts of the Archipelago, find there a quiet and comfortable asylum.

After a lengthy tour of instructive inspection through the hospitals of the European continent, he entered the navy as assistant surgeon, a position he held nearly two years, visiting a great many places in Europe, and making stations in several ports on the western African coast, chiefly in Sao Paulo de Loanda, the capital of Angola, where he enjoyed the privilege of the acquaintance of the distinguished and ever-remembered Dr. Livingstone.

The life of indolence and almost complete idleness led on board ship in the tropics being uncongenial to his tastes, he tendered his resignation and located in the city of Villa Vicoza in the province of Alemtejo, in Portugal, where he received the appointments of surgeon on the staff of the Mercy Hospital and city physician, positions he held until January 1, 1871.

At that date his brother and family were about to return to Chicago, where they had their home for over eighteen years, after a visit of a few months to the land of their birth and he concluded to accompany them to their adopted country. He arrived in Chicago in February, 1871, and while yet a new comer in this city of wonders, the great conflagration of October 8th and 9th, reduced to ashes his best possessions for he was located in the Calhoun building which was an early prey to the flames.

In the midst of the chaos and confusion which followed the great fire, when indigence and contagious diseases afflicted our overcrowded population, he volunteered his services to the Braynard Free Dispensary which he attended daily from one to two P. M.

The following episode deserves narration: One day the anteroom was crowded almost to suffocation; the first person to come before him was a man broken out with the small-pox; at a glance he saw the danger of his mingling with the other people and gave him a note to the county clerk to have him admitted to the small-pox hospital. The man left in quest of the County Clerk, and when the next patient was called there was no response and the anteroom was entirely vacated. The conversation had been overheard with that result. In 1883 was elected Prof. of Therapeutics in the College of Physicians and Surgeons of Chicago, which he held until 1890, when he resigned to take the chair of pediatrics, holding it for two years, when he severed his relations with the institution and went westward in search of a climate more congenial to the impaired condition of health of his family. In 1891, was appointed physician to the staff of the Cook county Hospital and served only a short time prior to his departure. He practiced medicine uninterruptedly in Chicago, from February 12, 1871, to October 28, 1891, and now after an absence of nearly two years, has found his way once more to the old stamping grounds.

Abstracts.

Medicine.

Electric Tests for Urine.—Dr. Lawson Turner is strongly in favor of the electrical examination of urine, and considers it to be much more accurate and convenient in determining the amount of urea than the ordinary mode. (*N. Y. Medical Times.*) The method is to place the urine in a V-shaped tube, this being connected with a measuring bridge. The resistance in urines depends mainly on the presence of chlorides. He recently instanced a case of pernicious anæmia where the urine had a specific gravity of 1,017, 9.36 grains of urea per ounce, on one day, and specific gravity 1,020, and 7.02 grains urea on another. From this nothing could be deduced; whereas much could be learned when one was told that the specific resistance in the one case was 68, and in the other 51 ohms. He has determined the electric resistances of various artificial fluids, and finds that a three per cent solution of urea gives a specific resistance of 382.5 ohms; a two per cent solution a resistance of 569.5 ohms; a two per cent solution of sodium chloride gives a specific resistance of 29.25 ohms; one per cent solution 59.5 ohms; a two per cent solution of sodium chloride mixed with a twenty per cent solution of grape sugar gives a resistance of 51 ohms. The specific resistance of distilled water is found to be infinite, and that of ordinary spring water enormous.—*Exch.*

Removal of Oxyuris Vermicularis.—In the *Correspondenz-Blatt fuer Schweizer Aerzte*, August 1, 1893, p. 540, Dr. Etter, of Thurgau, warmly recommends the following simple and "sure means (*Sicheres Mittel*)" far freeing patients from oxyuris vermicularis. Every evening, at bedtime, the patient is placed in a knee-and-elbow position, after which an assistant separates the anal folds as thoroughly as practicable, while the operator proceeds to catch discovered parasites one by one, by means of a *pincette* or a hairpin, or any appropriate instrument. The "hunting" (which at the first sitting secures a more or ever less abundant "booty," but subsequently becomes less "rich") should be diligently continued for several successive evenings, until no worms can be discovered. On the whole, a complete cure requires about three weeks' time.—*Provincial Medical Journal.*

Concerning Some Peculiarities of the Sense of Touch.—By G. Sergi, Rome, Italy (Zeitschrift f. Psy. und Phy. und Phys. des Sinnesorgame). The author first refers to the experiments by Bloch to determine the duration of the sensations of touch; first in 1875. later in 1877. Sergi desired to ascertain the acuteness of the skin's power for discriminating succcessive stimulations. In other words, how much of an interval must there be between successive touch stimulations to prevent their being fused into one continuous sensation. As apparatus, he used a series of six of König's tuning forks, set into vibration electrically, capable of thirty, 100, 250, 435, 500 and 1,000 vibrations respectively. These forks were applied directly to various portions of the dermal area. After a large number of careful tests, Sergi reaches some interesting conclusions:

1. The different portions of the dermal surface are by no means *equally* capable of perceiving touch stimulations of weak intensity. The most sensitive portions of the skin are the tips of the fingers on the volar side, where the weakest stimulations are distinctly perceived.

2. The minimum of energy of the stimulus (or threshold) varies with different portions of the skin and with successive isochronous stimuli, as those of the tuning fork, the continuous sensation which proceeds is not the result of fusion of the impressions but the result of the imperceivability of weak sense impressions.

3. The mucous membrane of the glands experiences no sensations of a purely *tactile* character.

4. Two conditions must ever be borne in mind—conditions which really complement each other: (*a*) the intensity of the stimulus; (*b*) the special sensibility of the stimulated organ. Helmholtz demonstrates the truth of these with reference to sensations of light.

The experiments of Sergi, in a general way, substantiate the earlier ones of Weber, Rumpf and Schwaner.—*Journal of Nervous Diseases.*

SOME NEW TESTS FOR ALBUMEN IN URINE.—1. Sublimate and acetic acid. If to urine containing albumen a few drops of a solution of sublimate, one per cent, are added, a distinct cloud is obtained, while in a normal urine this does not occur, or only in exceptional cases, when there is a very slight, hardly visible, clouding. If to the above a few drops of acetic acid are added, the cloud if not due to albumen disappears, when albumen is present the opalescence remains, even on the addition of acetic acid. A mixture of one part of acetic acid, and six parts of the sublimate solution only produces a cloud, when albumen is present, appearing immediately on adding the reagent, and does not give a deposit, while sublimate alone does so. Peptone gives no reaction; with the test in above proportions uric acid behaves in the same manner, also solution of una-phosphates or sugar; a concentrated urine also is not clouded by the test.

2. Sulphocyanide of potassium and acetic acid at ordinary temperatures. For this test 100 cc. of a ten per cent solution of sulphocyanide of potassium are mixed with 20 cc. of acetic acid, a few drops are added to the urine to be examined. If albumen is present in small quantities a distinct cloud immediately occurs. If albumen is plentiful a thick, white deposit is obtained. Excess of liquid makes no difference to the result. All normal urines give a negative result with the reagent. By successive dilutions this test appears to be more sensitive than the ferrocyanide of potassium and acetic acid. It has also the advantage of being colorless, and remains clear even after a lapse of time. These results are only obtained by following the above procedure closely.

3. If to urine, containing sulphocyanide of potassium, a small quantity of succinic acid is added, when albumen is present a clouding is seen, but not otherwise.

This reaction presents the advantage of being easy to carry since both bodies are solids. Equal, small quantities of each are mixed and added to the urine, and the reaction occurs at once if there is albumen. If the chemicals are mixed and enclosed in gelatine capsules they are easily carried and available at any moment, and perfectly reliable if kept free from moisture. — *Dr. Zouchtos Le Progres Medicale.—Times and Register.*

ÆTIOLOGY OF COLES.—Schenk (*Centralbl. f. Bakt.*, July 18th) has investigated the effects of warmth upon microörganisms. He finds that the bacteria examined in a hanging-drop preparation move toward the point at which, by means of a special contrivance, the temperature is highest. That this movement is a vital phenomenon and not the result of a mere flowing of molecules toward a point is proved by the fact that it is absent when fine granules of sepia are observed in place of bacteria. Upon this observation Schenk bases a theory of ordinary catarrh. The principal facts noted by him and the speculation based thereon may be summarized as follows: (1) Warmth excites movement in microörganisms; they tend toward the center of warmth (thermotaxis.) (2) Thermotaxis is a vital phenomenon of bacteria; it is manifested even when the difference of temperature between two given points is only 8 to 10° C. (3) Single organisms illustrate this tendency in greater degree than those united in chains. (4) Ordinary colds may be arranged in two groups; those due to bacterial infection and those independent of this. In the former there is a well-marked interval (incubation period) between exposure to cold and the onset of the malady; in the latter the disease follows quickly upon the exposure. (5) When a person enters a cold room, air bacteria tend toward his body as toward a focus of warmth. (6) Thermotaxis is one condition necessary to the development of an infection cold; the second is penetrability of the skin or mucous membrane to microbes, or some possible circumstances permitting their entry into the body. The penetration of skin and mucous membrane has been shown by various experimentors. In conclusion, it seems possible that some varieties of cold are traceable to air bacteria, acting under certain conditions of temperature.—*British Med. Jour.—Domin. Med. Month.*

THE MINOR SYMPTOMS OF BRIGHT'S DISEASE (Dieluafoy).

1. Auditory difficulties, ringing in the ears and deafness. Mounier has sought to bring the vertigo of Meniere's disease into this category.
2. Numbness of the fingers or hand was noted forty-six times in the sixty cases.
3. Chilliness of legs and feet observed thirty-seven times in the sixty cases.
4. Pollakiuria is equally common.
5. Pruritus, likened to the sensation produced by a hair on the skin.
6. Epistaxis, especially in the morning and starting during sleep.
7. The sign of the (temporal) artery. The arterial system is tense, the vessels are bent and hard (without there being arterio-sclerosis), and this is shown especially well by the temporal artery.

Each of these signs separately has little value; but collectively are enough to form the diagnosis.—*Le France Medicale.—Ont. Med. Jour.*

Surgery.

A NEW METHOD OF GASTROENTEROSTOMY.—Postnikow, of Moscow (*Centralbl. fuer Chir.*), describes a method of performing gastroenterostomy in which the establishing of a free communication between the stomach and duodenum is postponed until the third or fourth day after the date of operation. The following are the stages of this method, which has been tried with complete success on seventeen animals: 1, incision of the abdominal wall; 2, attachment of the selected loop of small intestine to the anterior wall of the stomach by sutures passed beneath the serous coats; 3, excision of a small oval piece from the wall of the stomach as far as the muscular layer, and of a similar piece of the same depth from the wall of the small intestine; 4, union by means of sutures of the posterior edges of the raw surfaces thus established on the stomach and the loop of small intestine; 5, constriction by the silk thread of the portions of mucous membrane protruded at the wounded surfaces of the stomach and small intestine after removal of the serous coat; 6;

union by sutures of the anterior edges of the opposed raw surfaces; 7, application of a second row of sutures passed beneath the serous coats; 8, closure of the external wound. In this operation the mucous membrane of the stomach and small intestine is not incised, but is closely constricted by two ligatures which, by causing gangrene of the protruded portions of these coats, and consequent separation, establish a free communication between the adherent parts of the gastro-intestinal tract. Postnikow states that by this method the escape of fæcal matter into the peritoneal cavity is prevented; the duration of the operation is shortened, and the necessity for washing out the stomach avoided.—*Exchange.*

Temporary Removal of the Kidney from the Abdominal Cavity.—I have twice removed the kidney from the abdominal cavity and after a thorough examination returned it. I am, I believe, the originator of this procedure.

The following was the technique observed: A T-shape incision was made in the lumbo abdominal region; the kidney was enucleated from its fatty capsule, the lower extremity of the kidney slowly brought out of the incision and finally the whole organ, the whole process bearing a great resemblance to the delivery of the fœtal head. Next the kidney was incised, a finger introduced into the pelvis and the whole organ explored bimanually. All indurated spots were freely incised and explored. Hæmorrhage was at once checked by a matrass, suture of catgut introduced by a round needle, and when necessary passing through the entire kidney, and the organ returned. In one case traction produced a slight laceration near the pelvis, from which free hæmorrhage occurred, readily checked, however, by a square suture. In one case a stone was found in the pelvis of the kidney and removed by a direct incision. In the other case, after a prolonged search, nothing was found except great enlargement (large gouty kidney). Both cases recovered.—*Dr. Haynes in So. Cal. Pract.*

Amputation of Entire Penis by the Gould Method.—The patient operated upon by Mr. Herbert Allingham was aged fifty-four. He had always suffered from phymosis, and for the past three months the penis had been swollen and there was an offensive discharge. On admission to the hospital the prepuce was slit up and a great part of the body of the penis was exposed. In both groins the glands were engorged. Mr. Allingham decided to remove the entire organ, as the dorsal lymphatics were nodular and evidently affected with cancerous infiltration (*Ex*). The scrotum was accordingly split, and the incision continued down to the center of the perineum. The penis was then seized and freed down to the attachments of the corpora cavernosa to the rami of the pubes; these were divided. The corpus spongiosum was next separated from the corpora cavernosa about an inch from the triangular ligament. The penis was removed and the corpus spongiosum split and attached to the skin wound behind the scrotum. The long incision through the scrotum was sewn up. The left groin was next attacked, and all the enlarged glands thoroughly cleared out, the femoral vessels being exposed in the dissection. The right groin was then in like manner thoroughly cleared.

Mr. Allingham stated that he felt confident this was the best operation to perform, as it cleared away all the dorsal lymphatics, and also said in these cancerous affections it was most important to cut free and wide of the cancerous growth.

Mr. Allingham said, should there be any recurrence in the groin, he intended to ligature the femoral artery and vein, and then to thoroughly clear away the whole of Scarpa's triangle, and if necessary turn up the peritoneum and clear away the external iliac glands.—*Med. Review.—Clinique.*

Diagnosis of Hereditary Syphilis.—Fournier insists that the diagnosis of hereditary syphilis must be based almost exclusively upon ocular evidence. Beyond a family history of infantile polymortality, verbal information has but little significance. To Hutchinson's triad of symptoms—notched teeth, interstitial keratitis and inflammation of the middle ear—must be added three other important evidences of specific trouble that do not always receive sufficient emphasis. First, the general appearance of the patient; next, the cicatrices upon the skin and mucous membranes; and, third, the deformities of the bones. Persistent childhood best describes the bodily condition, owing to the low stature and slight frame. The scars upon the skin and mucous membranes present four definite characteristics: their size, configuration, area and locality. They are very small, almost minute; in form like a rounded bow, an arcade or a serpentine curve. They are arranged in groups joined at the side, and are found at the commissure of the lips, about the circumference of the nose, in the throat, and particularly upon the buttocks and in the lumbar region. In the bony skeleton are the most strongly marked, the most profound and persistent lesions, easily discovered in the skull, in the face, in the bones of the extremities, most notably in the tibia. The forehead bulges outward, or may be keel-shaped, or may present symmetrical protuberances. There is often marked increase in the transverse diameter of the head, and the lateral halves of the cranium often show marked asymmetry. The characteristic deformity of the face is that of the nose. In the first type the upper part of the nose seems to have fallen in and the tip turned up; in the second, the lower portion of the nose is shortened and appears in some way to be absorbed into the upper part. There are also less typical nasal deformities, as when the nose is flattened at the base or badly formed, the result of simple dystrophy and not of necrosis. Protuberances and hyperostoses are found at the level of the epiphyses, especially noticeable at the upper extremity of the tibia and at the lower extremity of the radius and ulna. But the tibia is the direct revelation of syphilis. Its form alone will reveal this disease. It is large, thick and misshapen, much widened and depressed in its middle portion. The crest is so much increased in size as to present a plane face. In general effect the bone is like the blade of a sword. This conformation is never found in any condition other than hereditary syphilis, of which it is the pathognomonic sign. Chronic lesions of the testicle are of frequent occurrence. This, together with a history of middle-ear trouble, interstitial keratitis, notched teeth, small scars upon the skin and mucous membrane, the imperfections of the bony skeleton, the arrest or anomalies of bodily development, and

the special condition of the tibia, render the retrospective diagnosis of hereditary syphilis comparatively easy.—*N. Y. Medical Record.*

THE RADICAL CURE OF HERNIA BY IMPLANTATION OF BONE.—Thiriar, in *Le Mercedi Medical*, May 24, 1893, describes his method of radical cure for hernia by the implantation of a decalcified plate of bone. After carefully isolating the sac to above the internal ring, he then ligates and resets it. On being released the stump disappears within the abdomen. Between the peritoneum and abdominal wall a plate of decalcified bone is inserted; this is well held in place by the sutures which pass through the edges of the orifice and unite the pillars. The size of this plate is larger than that of the opening, and varies from three to five centimeters long, the same in breadth, and eight to twelve millimeters in thickness. The canal is sutured shut with catgut, and then the skin, drainage being put in if desired. The author states that he has practiced the operation twenty-five times in the past eight months, and as yet has had no relapses, and this notwithstanding he has done it in the worst of cases. In one of his earlier cases the plate was discharged in fifteen days, having been reduced about one-third in size. The patient, nevertheless, was cured, and remains so. The author claims that as the plate disappears, it is gradually replaced by cicatrical or strong fibrous tissue that effectually plugs the opening and prevents a recurrence.—*University Med. Magazine.*

AN IMPROVED OPERATION FOR VARICOCELE.—Dr. Edward Wyllys Andrews, of Chicago, says: The redundant scrotal skin is grasped as in preparing to apply the clamp. Having crowded the testes upward until there appears but little more room for them, and it is apparent that the skin over them is reasonably tense, the part below this is marked for removal, with all such veins pertaining to the varicocele as can be taken up with it. Now, instead of the clamp, a line of sutures is made to separate the portion to be removed from that above, the line being carried from the perineum forward in a curve to some point below the bulb of the penis.

If quilled sutures are inserted they should be placed one-half an inch apart and drawn not too tightly.

The plan the author prefers is to thread two silkworm guts upon straight needles and tie the other ends to each other, thus getting a long piece with a needle at each end. Beginning at the perineal end, the double stitch is now carried forward in loops of one-half or five-eighths of an inch in length, the needles inserted being from opposite sides and crossing each other each time until the front is reached, where the free ends are tied to each other.

One reason for preference for this form of deep suture is because it shortens the line as well as compresses laterally by a sort of puckering-string action.

Having secured contact of the two sides of the scrotum by this permanent substitute for the clamp, it only remains to divide the skin, and contained varices about half an inch below this line and secure all bleeding which the compression of the deep sutures may permit, after which a continuous horsehair or other superficial suture will complete the operation.

The author states that his success with this operation has been perfect. Union of the superficial wound usually takes place in five or six days, but the author prefers to leave everything untouched for about fourteen days, removing everything at that time, including the retention sutures, and sealing with collodion any small unhealed spots.

The operation should be done with rather minute care, especially in the final step of approximating the scrotal skin, which is thin and needs careful suturing with a fine needle and very numerous small stitches to insure nice closure. It is well to use a few horsehair drains, of a dozen or two fibers each, to remove the excessive serum by capillarity and prevent local distension.—*Indiana Medical Journal.*

Therapeutics.

NITROGLYCERINE FOR VOMITING.—Humphries (*British Medical Journal*, No. 1683, p. 693), reports having employed nitroglycerine systematically for three years in all forms of vomiting encountered, with highly satisfactory results. In cases of gastric catarrh in the adult or in the infant, acute or chronic, dependent upon alcoholism or upon anæmia, it acted almost as a specific. It also proved useful during pregnancy. In peritonitis alone it increased the vomiting, but the effect soon passed off. It proved of little value in the relief of the vomiting of pulmonary tuberculosis. In combination with catechu it acted well in several cases of lienteric diarrhœa. The vomiting of influenza was also relieved by the use of the agent, which was in no instance attended by bad results.—*Medical News.*

THE EXTERNAL APPLICATION OF CANTHARIDES IN DISEASES OF THE NOSE AND NECK.—Dr. C. Ziem recommends painting cantharidal collodion not only behind the ear, but extending thence downward as far as the angle of the jaw, in abscesses of the thyroid gland, inflammation of the frontal sinus and antrum of Highmore. The same method is applicable to ocular affections dependent upon nasal suppuration. —*Deutsche med. Zeitung.—Med. Bulletin.*

COMBINED EFFECTS OF MORPHINE AND SULPHONAL. —Gonzales (*Arch. di. Farmacol. e di Terap.*, recognizing the good points in the action of this hypnotic, but realizing also that its effects in man are not quite so satisfactory as the results of experiments on animals would have led us to think, was led to try to reinforce its action by association with morphine, the main trouble with sulphonal being that the sleep is neither very deep nor very lasting. The subject was first investigated on frogs, with the following results: Sulphonal alone in the mean dose of 0.04 gramms causes no symptoms save abolition of voluntary movements for some hours. Morphine alone (0.008 grammes hydrochlorate) produces marked excitement, lasting for about an hour, the animal then returning to normal. The two drugs given in combination in the same doses caused marked and lasting narcosis, lasting for many hours. On the heart *in situ* sulphonal alone causes a slight diminution in the frequency, but increase the strength of the systole, and the amplitude of the diastole. Morphine alone only reduces the frequency. The mixture of the two drugs is without action on the frequency, but increases the force of the systole and amplitude of the diastole. Similar results were obtained in the case of the isolated heart. The results on mammals were as fol-

lows: In rabbits (doses forty centig.) and dogs (doses seventy-five centig.) sulphonal produces sleep generally in half an hour from the administration, the reflexes and respiration being unaltered, and the heart beats frequent and vigorous; but the sleep is not at all profound, and in dogs is sometimes wanting. Morphine produces it in rabbits about twenty-five minutes after the injection, but the animals soon shake it off; in dogs it lasts a still shorter time. The mixture of the two drugs is perfectly successful both in dogs and rabbits. The sleep appears physiological, and lasts from seven to ten hours, and is not in any way complicated by unpleasant sequelæ; the heart and respiration are unaffected. The author finally recommends this mixture of the two drugs as an admirable and safe hypnotic, free from cardiac depressant action, and efficient even in insomnia due to neuralgia and nervous excitement.—*Med. and Surg. Reporter.*

Some Medical Opinions on the Abuse of Alcohol:—Dr. Higginbottom says: "That in a long and busy practice, in his opinion, its administration in typhoid and typhus fevers is injurious, and often fatal in its effects."

Dr. Richardson says: "That in a large private and hospital practice the stopping of alcoholic stimulants has been attended by a largely diminished death rate."

Dr. Wilson, of Philadelphia, in his work on continued fevers, says: "Alcohol forms no necessary part in the routine treatment of typhoid fever."

Sir Wm. Jenner says: "The large proportion of typhoid fever patients get along better without it from beginning to end."

Dr. Beaumont, Lecturer on Materia Medica in Sheffield Medical School, says: "I have treated several thousand cases of all kinds occurring in general practice without alcoholic liquors of any kind, and have been gratified with the result. The medicines take effect most potently and answer their end better."

Dr. N. S. Davis, of Chicago, says: "In my ample clinical practice I have for over thirty years tested the medical uses of alcohol, and have found no cases of disease and no emergencies arising from accidents that I could not treat more successfully without any form of fermented or distilled liquors, than with them."

Furthermore, he says: "That if any one will take the trouble to examine and analyze carefully the records of the large general hospitals of both Europe and America for the last half century, he will find the ratio of mortality from general fevers and acute diseases to have increased *para passu*, with the increase in the quantity of alcohol consumed in the treatment. —*Medical Mirror.*

Salicylic Acid as a Vermifuge.—Dr. Ozegowski (*Nowiny Lekarski*).—This physician employs salicylic acid successfully, it is reported, to expel tænia, in the following manner: The patient abstains from food on the day preceding the treatment, taking 30 grammes (1 fl. oz.) of castor oil in the evening and 15 grammes (½ fl. oz.) of the same purgative at seven o'clock the next norning. From eight o'clock on he takes hourly, for four hours, a cachet containing one gramme (15 grn.) of salicylic acid. If the tænia should not be eliminated within an hour after the 4th cachet, a new dose of 15 grammes (½ fl. oz.) of castor oil is prescribed, when the parasite is generally expelled.

The treatment has failed, it is reported, only once in twenty cases in which the author had occasion to employ it.—*Am. Med.-Surg. Bulletin.*

The Hot Bath in Therapy.—Dr. Baelz (*Münich. Med. Wochenschr*, 1893; No. 18).—At the recent Medical Congress at Wiesbaden, the author related the results of his careful study of the hot bath make in Tokio, Japan, where it is much employed, and frequently taken as warm as 41° C (105.8 F.).

The hot bath raises the body temperature to 40°–41° C (104–105.8 F.), increases the pulse-rate, and dilates the blood vessels; but it does not weaken or depress, nor favor taking cold as does the warm (36.6° C [98 F.] or lower) bath. It is recommended, on entering the hot bath, to pour hot water on the head so as to prevent cerebral anæmia.

The hot bath is a derivative remedy, and is indicated, according to Dr. Baelz, in capillary bronchitis, lobor pneumonia, rheumatism, nephritis, and uterine colic accompanying menstruation. Three or four baths are given a day.—*Am. Med.-Surg. Bulletin.*

Atropine in False Croup.—Atropine is advocated in *false croup*, to be given in the following manner: One one-hundredth of a grain is dissolved in a glass of water and a teaspoonful given hourly. Estimating a glass of water to contain about six ounces, or forty teaspoonfuls, the dose would be one four-thousandth of a grain, and yet this is strictly physiological medication, and, moreover, it is successful, entirely free from the debilitating effects of the nauseating mixtures which have so long been in vogue. The theraputic value of this practice is explicable by reason of the well-known disposition of belladonna or its active principle to affect the tissues of the throat. Whenever the drug begins to find an outlet through the cells covering the mucous structures, then these cells have their functions stimulated by the irritation of a foreign substance, and, so far as possible, they attempt to eliminate the poison, and with it go the morbid products which have contributed to produce the disease. And it will readily be seen that large doses, by destroying the functional activity of the cells, would defeat the very purpose for which the medicine was exhibited. What folly then, to give a child a dose sufficient to set up a factitious disease alongside of the real disease, destroying the functions of the cells upon which we ought to depend for the restoration of the affected tissues. It also shows the fallacy of the old maxim that if a little is good, more will be better, at least, it proves that in some instances it does not apply in the practice of medicine.—*American Theropist.*

Treatment of Ringworm.—The recent treatment of tinea tonsurans shows a strong tendency toward the use of losophan, a new and very active mycotic which has been giving remarkably good results. Losophan is a tri-iodocresol, very rich in iodine (about eighty per cent), with which, on application to dermatc lesions, it slowly parts, thus avoiding toxic effects, while making the pathological field untenable for living organisms. For these reasons, losophan is indicated in all cutaneous conditions due to the development of the trycophyton fungus, in mycosis,

pityriasis, sycosis, prurigo, pendiculosis, and in all of the large groups of skin diseases due to the presence of filamentous fungi or microspores. The clinical reports advise the use of losophan in one to two per cent ointments with lanolin or vaselin. Where a wash is needed, a solution should be made of one or two parts of losophan in a mixture of twenty-five parts of water with seventy-five parts of alcohol. The mixture keeps well. Losophan has already been tested in the treatment of phimosis and chancre. The best results were gained from a one per cent powder dusted over the lesions.—*Albany Medical Annals.*

NEW TREATMENT FOR CHLOASMA.—Prof. Unna treats freckles, chloasma, acne, rosacæa, scars, and other disfigurations of the face by removing almost the entire thickness of the epidermis by means of remedies which produce an effect similar to a blister. The method is termed "ecorchement." Two mixtures are employed, the first consisting of the following:

℞	Resorcin	40 grams.
	Oxide of zinc	10 "
	Anhydrous salicylic acid	2 "
	Lard	20 "
	Olive oil	8 "

The patient is instructed to apply this ointment several times a day. At the end of three or four days the skin will be found dry and chapped.

The second mixture should then be applied, which consists of the following paste:

℞	White gelatin	4 grams
	Oxide of zinc	3 "
	Glycerine	5 "
	Distilled water	8 "

Apply while hot, and cover with lint. In a few days the epidermis becomes detached, and may be removed together with the dried paste by snipping the edge with a pair of scissors. This remedy is painful, but it is said to be quite successful; it has been used in the St. Louis Hospital, Paris.—*Bact. World and Mod. Med.*

Ophthalmology.

TREATMENT OF MARGINAL BLEPHORITIS BY MEANS OF A SOLUTION OF CORROSIVE SUBLIMATE IN GLYCERINE.—Dr. Despagnet, of Paris, says that he obtains the best results by painting the margins of the lids, on the roots of the eyelashes, with a solution of from one to three per cent of bichloride of mercury in glycerine. The application must be made by the surgeon every second day, after the eyelashes and scabs have been removed. After the application, the part is dried with a piece of absorbent cotton, and, if necessary, the pain is relieved by applications of cold water. The improvement is marked after the first week, but two months are needed to obtain a permanent cure—a relatively short time for such an inveterate disease.—*Therapeutic Review.*

EARLY DIAGNOSIS OF LOCOMOTOR ATAXIA FROM EYE SYMPTOMS.—Hansell, of Philadelphia, discusses the possibility of the early diagnosis of locomotor ataxia from the eye symptoms. The conclusions are: Transient ptosis, or external ocular paralysis, may be one of the earliest symptoms of locomotor ataxia. The Argyll-Robertson pupil, uniocular or binocular, may precede, for a variable length of time, the general symptoms of locomotor ataxia. Idiopathic non-inflammatory atrophy of the optic nerve may be the first manifestation of locomotor ataxia. Transient ptosis, or diplegia, Argyll-Robertson pupil, incipient optic-nerve atrophy, associated in an individual past middle life, of inherited neurotic tendency, are strong presumptive evidence of the first stage of locomotor ataxia.—*The Journal of Nervous and Mental Diseases. Univ. Med. Journal.*

THE TREATMENT OF CATARACT WITH SUCCUS CINERARIÆ MARITIMÆ.—Dr. E. B. Wenner (*Times and Register, April 15, 1893*), reports a case of cataract causing total blindness in an aged person, with very encouraging results at the time of writing. Two drops were instilled into the eye three times daily; about two weeks after commencement of this treatment the patient began to notice the difference between light and darkness; one week later she could distinguish the hand, when placed between her eyes and the window. At present, she is able to distinguish the movements of the fingers before her eyes. The doctor is still continuing the treatment with hopes of entirely removing the opacity.—*Therap. Review.*

GONORRHŒAL IRIDO-CHOROIDITIS.—This is rather rare, considering all the cases of existing urethral disease. In the *Annals of Opthalmology and Otology* Dr. C. S. Bull reports two cases typical in nature. In both an arthritis followed shortly after the beginning of the gonorrhœa, and shortly afterward an eye became inflamed. This was characterized by severe pain, photophobia, and scalding lachrymation, excessive ciliary and conjunctival injection, chemosis of the ocular conjunctiva, cloudy aqueous humor, discolored and immovable iris, posterior synechiæ and extensive exudation into the vitreous humor, masking effectually the fundus. Vision was reduced to nearly simple perception of light, and the tension increased. The pain in and about the eye was excessive.

Leeches were applied to the temple; hot fomentations were constantly applied, atropine and cocaine locally instilled in the eye, and internally large doses of sodium salicylate administered; this latter was later changed to potassium iodide. The cases turned out well, as is the rule where they are treated wisely from the beginning.

It will be noted that the irido-choroiditis was preceded by a distinct rheumatic affection of some joint; that it was sudden in its onset, very rapid in its development, the pain excessively severe, andthe loss of vision very rapid and complete—a picture sufficiently startling for the equanimity of any observer. However, the fact that the main cause of the rapid and great deterioration of vision was a diffuse serous exudation into the aqueous and vitreous humors, explains the excellent results of treatment.

No doubt, less typical cases than those described by Dr. Bull occur; in fact, we have seen them assume a chronic form, and so remain intractable to the line of treatment suggested or any other that seemed rational. Finally, however, even these recovered and with good vision. Here, as in other cases, the personal equation counts for much, and it will hardly be wise to give a prognosis of too rapid a recovery.

The cases of this nature which have come under our personal study have resulted quite satisfactorily under a line of treatment similar to that outlined by

Dr. Bull. Especially useful have we found large doses of sodium salicylate.—*Med. Age.*

Diseases of Children.

PECULIAR SYMPTOMS IN AN INFANT DUE TO CONTRACTED PREPUCE.—Dr. S. E. Moses reports a case of an infant, two months old, weak and delicate, who was suffering from an attack of whooping cough, was suddenly one night attacked by what was described as inward convulsions. I sought the aid of Dr. Crombie, and on inquiry found that the child generally cried before passing urine, and that the so-called fits came on every two hours or so. Our attention was drawn, therefore, to the urinary organs, and we found a long, tight prepuce with a pin-point opening. We were fortunate, for while we were examining the child, a fit came on. There was no convulsive twitchings or spasms of any kind; on the contrary the child lay limp and lifeless; the respiration stopped, and we had to resort to artificial breathing for some time before the infant breathed, and then it came in gasps for some minutes till eventually the respiration became normal. The heart beats were twenty in the minute, and gradually as the respiration returned they rose to 120. The lips were livid, the eyes fixed and not sensitive to touch. The child passed urine and the fit shortly after wore off. I watched the child in several such attacks—some lasting fifteen to twenty, and twenty-six minutes. Dr. Crombie and I gave strychnine, but without effect, so on the following day we decided upon slitting up the foreskin, which we did, and no fit such as described has again returned. I would wish in this case to point out the crying of the child before the passing of water, the regularity of the return of fits every two hours, the time the bladder took to fill, and the passing of water before the fit wore off, and the immediate cessation of fits after the operation.—*Indian Med. Gaz.*

DISEASES OF FIRST DENTITION.—At the Academy of Medicine in Paris, a discussion recently occurred upon the subject of the diseases of first dentition. The question under consideration was: Are these disorders physiological or pathological? M. Magitot had previously maintained the absolute falsity of the doctrine which has been held from the days of Hippocrates down to the present time, relating to the disorders which occur during the dentition of infants, and declares that they should be erased from the category of medical nosology. MM. Constantin, Paul, Peters, and others attacked this position; but it is still stoutly maintained by Magitot, that the first dentition is a purely physiological act, and the newborn infant is not necessarily an invalid. He protests most vigorously against the idea that at the moment of the eruption of the teeth, the gums should be the seat of any traumatism, wounds or laceration. He discards the barbarious practice of incising the gums of the teething infant, and finally appeals to comparative pathology. He maintains that domestic animals as well as the human infant present, in the early weeks of their existence, symptoms which are entirely similar to those which are attributed in man to dentition, save that dentition is not present. He maintains absolutely his first position, in which he denies the existence of maladies of dentition.

M. Magitot's views were still combated by M. Carpentier, but his views seem to us to be based upon facts and maintained by logical reasoning.—*Bact. World and Mod. Med.*

Diseases of Women.

MISSED ABORTION. — Liebmann, of Buda-Pesth (*Centrälbl.f. Gynak*, from the *Arvosi Hetilap*), relates a case in which the remains of a fœtus which had died *in utero* were discharged piecemeal. A 3-para suffered at the fourth month of pregnancy from a fœtid sanious discharge, which lasted for two weeks; then pieces of fœtal bone began to come away. The process took about seven months, with intervals corresponding to the greater or less strength of the uterine contractions. Some of the bones were discharged singly; some remained articulated and required forceps for their removal. The placenta came away four and a half months after the beginning of the abortion. The number of bones that were thus gradually delivered amounted to over seventy, and indicated that the fœtus had reached the third month. —*Brit. Med. Jour.*

CARE OF THE PREGNANT WOMAN.—It often seems a wonder, to the thinking physician, that more women do not die from the effects of childbirth than do. Surrounded as they are by conditions prejudicial to health, having in many instances the care of a family of children and of the home up to a late period of gestation, going through the entire period up to the time of the delivery without any advice from a medical man, what wonder is it that many die, still more suffer unnecessarily, and comparatively few escape altogether, evil results from what, under proper conditions, should be without danger to them.

Dr. Duff, of Pittsburgh, (*American Gynecological Journal,*) makes a plea for the rational and scientific care of pregnant women by the physician. He considers it the physician's duty, on every occasion before attending a woman in labor, to ascertain the personal as well as the family history, treat any diseased conditions present, mark out a hygienic regimen, ascertain her ability to withstand the throes of labor, in short, to have a complete and comprehensive knowledge of the woman, and so be able to anticipate any accident or abnormal condition which may arise during her labor, and to ward it off, or at least treat it promptly. She should always be examined by the physician some time before her expected confinement.

The views of Galabin, that eclampsia often depends upon albuminuria and uræmia have been sustained by the experience of many obstetricians. Examinations of the urine of pregnant women is of great importance in establishing these conditions. The method of treatment yielding the best results is that with the saline diuretics and a complete change from an animal to a milk and vegetable diet.

The vomiting of pregnancy often proves stubborn. The treatment is empirical so long as the true cause of the condition is unknown. Oxalate of cerium seems to be the most effective remedy, and has succeeded after others had failed.

Various digestives have been used with success in some cases. Champagne and cracked ice will be

retained by the stomach usually. Koumyss is a valuable food. In extreme cases, abortion has been performed, but it is not considered justifiable by many practitioners.—*Clinique.*

EFFECTS OF MORPHINE ON THE FEMALE ORGANS.*—Passower recently read a paper before the Obstetric Society of St. Petersburg, in which he related the course of two cases under his own observation. It confirmed an opinion, already supported by the observation of others, that the abuse of morphine eventually leads to atrophy of the female organs. Passower's cases were of the ages of twenty-nine and thirty. One consulted him on account of the resultant amenorrhœa. The drug was discontinued, and the catamenia reappeared. The patient took to morphine again, and straightway the menses ceased. Between 1887 and 1889 Passower observed the case; sixteen pounds' weight was lost, and the sucutaneous fat disappeared. The vulva atrophied. The measurements of the uterus during that period ran as follows: December, 1887, $3\frac{1}{10}$ inches; May 1888, $2\frac{9}{10}$ inches; November, 1888, $2\frac{7}{10}$ inches; April, 1889, $2\frac{3}{5}$ inches; September, 1889, $2\frac{3}{10}$ inches, and July, 1890, $1\frac{9}{10}$ inches. The atrophic process no doubt began in the ovaries and spread to the other parts of the genital tract. This is evident from the early appearance of amenorrhœa and the later atrophy of the vulva, and also from physiological evidence; thus the submaxillary glands atrophy in dogs subjected to doses of morphine. How much of the drug can be taken without danger of these ill effects is entirely an individual question.

CARCINOMA OF THE UTERUS.—Dr. Lattocasa has recently operated successfully upon a woman, æt. twenty-seven, for this disease, while the woman was pregnant. The neoplasm removed was a papillary carcinoma, involving the cervix uteri.

At first pregnancy was not considered, on account of the absence of all definite symptoms, and because the neoplasm was of such a nature and size that it would prevent the entrance of the semen. From the clinical symptoms the following conclusions might have been deducted:

First, a possible pregnancy in the first month; which, if it did exist, would not contra-indicate the performance of a vaginal hysterectomy.

Second, generally, in carcinomata of the external os, when pappilomatous in nature, Bottini's method may be followed. This consists in simply removing the cervix uteri with the galvano-cautery. By this method the neoplasm is removed without loss of blood, and with little or no chance of deeper infection.

Third, when the new growth is very large and does not permit of enucleation through the pelvic outlet, a high amputation of the neck may first be performed, before resorting to abnominal hysterectomy.—*Am. Med.—Surg. Bulletin.*

THE RECIPROCAL EFFECTS OF PREGNANCY AND CHILDBIRTH ON THE OPERATION FOR SHORTENING THE BROAD LIGAMENT. — Alexander (*Annales de Gynecologie et d' Obstetrique*, Vol. xxxix., 1893) says that many have accused the operation of Alexander of provoking abortions. In reality the author states that the shortened round ligaments do not entirely support the uterus, but they maintain it in a normal position. Enlargement of the uterus during pregnancy does not produce lengthening of the round ligaments, but simply dilatation at the point of ligamentous attachment. Any lengthening that might take place is corrected during the postpuerperal period. The author reports seven cases operated upon by himself, all having become pregnant; the uterus did not return to the position for the relief of which the operation was required. —*Therapeutic Gazette.*

TREATMENT OF VAGINISMUS DUE TO LARGE FRÆNUM.—Dr. B. E. Hadra, of Galveston, read a short paper before the recent session of the Texas State Medical Association, entitled "Contribution to the Pathology of the Fourchette." He related a case where a young couple had a very hard time in their sexual relationship, owing to an excessively large frænum that made the insertion of the male member very difficult and painful, and led to almost a full vaginismus. The true condition was found out only when her child was born. The fourchette had then to suffer a thorough rent. Afterward, everything became perfectly satisfactory. Induced by this experience, Dr. H. paid close attention to the condition and form of the frænum, found it of very different size in the examined females, and came to the conclusion that many cases of dispareunia, and even full-fledged vaginismus, may be caused by such megalofræna, as they are liable to be irritated and fissured by cohabitation. They then become, in pathological respects, as troublesome as rectal rents, causing all kinds of nervous reflex suffering, etc. He thinks that the most sensible way to treat them is simple discission. —*Va. Medical Monthly.*

PASSAGE OF THE SOUND THROUGH THE UTERUS.—Jacobs, in operating upon a woman, thirty-six years of age, subject to chronic endometritis, introduced the sound cautiously and found that it passed upward to its hilt. The point could be plainly felt under the parietes. As no force was used, he concluded that it had passed through an old metroperitoneal fistula. It was withdrawn and passed in the lateral direction, when the uterine cavity was found three and one-fourth inches long. The uterus was packed with iodoform gauze; no fever or other evil result followed. The opening, however, persisted. Walton believed that in this case the sound passed through a dilated Fallopian tube. The writer in two instances has punctured the uterus in passing uterine bougies; in one the abdomen was opened and the opening sutured. In the other the uterus was packed with iodoform gauze. The puncture did not affect the subsequent convalescence in either case. A patient came under observation some years ago, in whom the sound could be passed through, apparently, the anterior wall of the uterus whenever it was introduced in a certain direction. This patient experienced no inconvenience from it.—*Centralblatt f. Gynäkologie, Univ. Med. Journal.*

PREGNANCY AFTER THE REMOVAL OF ONE OVARY AND PART OF THE OTHER.—Sippel reports a double ovariotomy in a woman thirty years of age, who had one child five years old and was very anxious for another. The right ovary was converted into a tumor the size of a child's head, and without a trace of normal ova-

*Centralbl. f. Gynak., No. 2, 1893, *Br. Med. Journ.*

rian tissue. This was removed with its tube. The other ovary was the size of a goose-egg. Along the hilum was a long tract of normal tissue. A clamp was applied above this tract to check hæmorrhage and the diseased part of the ovary cut away; the raw surfaces left were united by means of catgut sutures, while some blood-vessels were tied separately. This healthy part was an inch and a half long and a third of an inch thick; the left tube was undisturbed. Menstruation returned after the operation, and ceased on the 22d of August, 1891; on the 7th of April pregnancy was progressing favorably, and she was safely delivered of a living child.—*British Medical Journal, Univ. Med. Journal.*

Otology.

AURICULAR VERTIGO CAUSED BY BATHING.—Dr. Rutten, of Namur, reports the case of a man who was attacked, two days after bathing in a stream, by deafness, headache, general prostration, nausea, vomiting, buzzing in the ears, and severe vertigo. He had first experienced vertigo while in the water, and, although a good swimmer, would have drowned had he not received assistance from his son. Immediately after leaving the water he was seized with chills, cold sweats, and had to be taken to his home. No alterations were found in the external or middle ear or in the Eustachian tube. There being no signs of a cerebral apoplexy, the writer ascribed the symptoms to a functional trouble or a lesion of the internal ear, produced by contact of cold water with the tympanum. Such an action of cold water is more rapid in nervous subjects or in those suffering from disease of the ear. Perforation of the tympanum, permitting the introduction of water into the middle ear, merits special mention. A plug of wax or piece of cotton, swollen and displaced by water, may, by increasing pressure upon the tympanum, cause auricular or epileptic vertigo in certain special cases. The writer believes that the vertigo is produced by an alteration in the pressure of the liquid of the labyrinth, due to the action of cold water.—*Revue de Laryngologie, etc.—Medical Bulletin.*

COMMUNICATIONS.

Dr. Hammond and the Medical Profession.*

SIR: My respect for and my sympathy with the medical profession in America, and my knowledge of their sentiments, forbid me to regard Dr. William A. Hammond as their representative in the defense which he puts forward in the columns of the *New York Medical Journal*, September 16th, of the practices of publicity hunting, by newspaper interviews, newspaper portraits and of the use of and traffic in secret preparations, etc. I have in the course of recent travels received personally from many hundreds of prominent and representative physicians in Milwaukee, Washington, Boston, Philadelphia, Chicago, Cincinnati, Detroit, and from all parts of the United States, their cordial congratulations on the tone and substance of the addresses which I had the honor to deliver at Milwaukee and Washington. I have been assured on all hands of the entire sympathy of the great body of the profession in the views therein laid down and discussed. I should have been surprised, however, and perhaps disappointed if they had not elicited some expression of pain and anger from certain quarters. "Let the galled jade wince; the withers" of the great American medical profession are, I am assured "unwrung." Your correspondent, in an access of ethical agnosticism, assumes that the enumeration of ethical data as to medical conduct was, or could be, a reproval direct or implied to the medical profession of America. That is an unmerited insult which he addresses to his profession, and indicates a view which I apprehend to be special to himself. Let him enjoy the practices which he defends; I do not think he is likely to find much support or sympathy in them from medical men in good standing. His account of the position of the medical men in Great Britain is a parody undeserving of serious notice. So, as to myself, whom he favors with some personal abuse, I have been avowedly the scientific advisor to, but it is untrue that I have ever held any of the stock of the Apollinaris Water Company. As to his other trivialities, I was the guest of the Pan-American Medical Congress, and on entering its headquarters I registered in ceremonious form.

I have no desire to be honored among "the Pan-Anglicans," "the loyal legion," the "Fat Men of America," and the other objects of lay interest with whom Dr. Hammond puts medical men on a par, and I do not agree with him that medical men should desire to share with them the honor of newspaper notoriety. I do not believe any details of my medical career have ever appeared in any lay paper.

I suggest that it might be desirable for Dr. Hammond to rely less upon his imagination for his facts, and not to assume to speak for a profession from which he has no sort of mandate, and which would, I am well assured, repudiate, if consulted, both his advocacy and his methods of action and of expression.

I am assured that he utterly misrepresents that profession both in his statement of principles which he ascribes to it, and in his abuse of myself. I am, sir,

Yours faithfully,

ERNEST HART.

Analysis of "Cerebrine."

To the Editor:—I send you this very valuable contribution of Prof. Delafontaine (whom you must know as one of our best analytic chemists) on the chemical composition of Hammond's cerebrine and meduline. This examination was made largely at my suggestion. I found what I supposed was the physiological action of nitro-glycerine by internal administration, and so reported to Mr. Baker, and he suggested that an examination be made of it by Prof. Delafontaine, which has been done, and I hope you will publish the results in your journal.

Yours truly,

D. R. BROWER.

Some time ago Mr. Baker, of the firm of Gale & Blocki, asked me to make a chemical investigation of a sample of a drug in a small trianglar blue glass bottle, labeled "Sterilized Solution of Cerebine, prepared solely by Columbian Chemical Co., New York," with a fac-simile of William A. Hammond's signature in red ink across the label.

On experimenting on himself with that drug Mr.

Baker felt the rapid and powerful effect of a more than full dose of nitro-glycerin; which made him strongly suspicious of the presence of the latter in that alleged cerebrine. Having put five drops of that fluid on my tongue, I felt the same symptoms described by Mr. Baker, followed by the same occipital headache.

Then I proceeded to the chemical examinations as follows: The excipient in that solution is chiefly glycerin. A part of it was treated with mercuric chloride, which gave but a faint flocculent precipitate. No change with potassium iodo mercuriate. Therefore absence of ptomaines or other organic bases. To another part of the liquid were successfully added diphenylamine hydrochloride and strong sulphuric acid, which developed the intense deep blue color characteristic of *nitric acid* or *nitrates*.

A few drops mixed with ferrous sulphate and sulphuric acid produced the brownish color also characteristic of nitrates. On the other hand, sulphanilic acid used in conjunction with dilute hydro-chloric acid and naphthylamine hydrochloride failed to show the presence of nitrous acid or its salts. Now, one of the properties of nitro-glycerin is that it is decomposed by alkalies into a number of compounds, among which are nitric and nitrous acid.

Some of that combine was saponified by caustic soda and the excess of alkali sursatuated. One-half of the fluid gave with diphenylamine the nitrate reaction. The other half showed the beautiful red color due to tritrites when treated with sulphanilic acid and naphthylamine. Thus it is seen that the cerebine solution is also saponified by caustic soda, with the production of nitric and nitrous acid. I have also experimented on an unbroken package of *medulline* prepared by the same concern. Physiologically and chemically the results were the same, so that it is unnecessary to describe them.

On the other hand, a sample of cerebrine made by another firm proved to be physiologically inert and utterly failed to give any of the color reactions described in the foregoing lines.

The chemical reactions of Hammond's cerebrine and medulline fully agree with the physiological effects in that they point out the presence of nitro-glycerin, or some very closely allied product which does not preëxist in the ox brain. Personally, I do not believe in some putrefactive process generating a nitrate in the Hammond's product. The absence of ptomaines excludes that theory.

M. DELAFONTAINE.

BOOK REVIEWS.

"Text-Book of Ophthalmology." By Dr. Ernest Fuchs, Professor of Ophthalmology in the University of Vienna. Authorized translation from the second enlarged and improved German Edition, by A. Duane, M. D., Assistant Surgeon Ophthalmic and Aural Institute, New York. D. Appleton & Co., New York.

The present translation of Prof. Fuch's work is taken from the second improved and enlarged German edition, well and favorably known abroad. The translator has succeeded admirably in adapting his work to the American readers, and shows ability and conscientious care in its preparation.

The work is divided into four parts as follows:

1. Examination of the Eye.
2. Diseases of the Eye.
3. Anomalies of Refraction and Accommodation.
4. Operations.

An appendix is added, describing various instruments used in ophthalmology.

All ophthalmologists will appreciate this addition to their special branch of the medical science, on account of the special care in the presentation and selection of facts, thoroughness of information given and scientific accuracy.

"Syphilis and the Nervous System;" a Revised Reprint of the Lettsomian Lectures for 1890. By W. R. Gowers, M. D., F. R. C. P., etc. Philadelphia: P. Blakiston Son & Co. 1892. Duodecimo, 132 pages; cloth, $1.

These lectures have been issued in a compact and convenient form by the author on account of the earnest wish of many to preserve the original articles which appeared from time to time in medical journals. They have been carefully revised and additions made, increasing the practical value, and at the same time bringing the original lectures up to the present knowledge.

"Mother and Child." Part I., the Mother, by Edward P. Davis, A. M., M. D. Part II., the Child, by John M. Keating, M. D., LL.D. Philadelphia: J. B. Lippincott Co. 1893.

The author states that it has been his aim not to supplant the advice of the physician, but to supplement same and render intelligible those matters that mothers and nurses find difficult to understand. A great deal of good advice is given in the first part regarding the proper care of the health in girlhood, at the period of puberty, and during womanhood, and writings and opinions of many physicians are quoted.

Part II. gives many valuable and simple methods of preparing food for the infant, and the sterilization of milk and care of the nursing bottle are described in such manner as are easily understood by the majority of primiparæ.

Diseases of children, such as croup, measles, chicken pox, scarlet fever, etc.; are thoroughly described, with modes of infection and prevention of same, and with the index reference to the text is easily accomplished. This is not only very valuable to the physician, but will make a work that should be found in the home of many.

"International Clinics." Third Series. Vol. I. A Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Genito-Urinary Surgery, Gynecology, Ophthalmology, Laryngology, Otology, and Dermatology, by Professors and Lecturers in the leading medical colleges of the United States, Great Britain and Canada. Edited by John M. Keating, M. D., LL.D., Judson Daland, M. D., J. Mitchell Bruce, M. D., M. R., C. P., and David W. Finlay, M. D., F. R. C. P. Philadelphia; J. B. Lippincott Co., Publishers.

With each volume of the International Clinics the value of the work as a whole becomes more and more apparent to the general practitioner. The lectures, delivered by both American and European professors bear the impress of careful preparation, and the subjects are brought up to the knowledge of that particular branch at the time. There is something of special interest to every class of practitioners, whether general or special, and those who have not yet subscribed would do well to do so with the commencement of this third series.

"System of Diseases of the Ear, Nose and Throat." Edited by Charles H. Burnett, A. M., M. D., Emeritus Professor of Otology in the Philadelphia Polyclinic: Clinical Professor of Otology in the Woman's Medical College of Pennsylvania; Aural Surgeon to the Presbyterian Hospital, etc., Philadelphia, Pa. Volume I. Illustrated. J. B. Lippincott Company, Philadelphia. 1893.

The contents of Volume I. are divided into two parts. Part I., Diseases of the Ear, and Part II., Diseases of the Nose and Nasopharynx.

The close anatomical and pathological relations existing between the ear, the nose and the throat render it necessary that these different diseases often be treated by the same one, whether he be general practitioner or specialist. Even with the latter, cases present themselves where a knowledge of the morbid processes in all of these organs is absolutely necessary for the proper treatment of special maladies in any one of them. This systematic work renders it unnessary for a busy medical man to have to refer to numerous works on various subjects, the editor having endeavored to place before the profession a practical work composed of papers by eminent authorities upon the subjects above mentioned.

Publisher's Department.

Sennine, the new American antiseptic, nonpoisonous, nonirritant, odorless, is a product of boracic acid and phenol.

Convenient, inexpensive, applicable in powder form and dressing. One ounce dissolved in boiled water makes one quart of liquid of proper strength.

Externally, five parts of sennine dissolved in 100 parts boiled water will be of desirable strength for an antiseptic surgical wash and for the treatment of catarrhal affections of the mucous membrane of all parts of the body. An excellent dressing for burns, scalds and sores is obtained by mixing one part with ten parts of vaseline.

Internally, one to five grains of sennine, three or more times a day, is a powerful remedy in fermentative dyspepsia, typhoid fever, cholera infantum, cholera Asiatica (especially as a rectal injection, five per cent), and other fermentative diseases of the stomach and bowels.

Lister's Renewed Allegiance to Carbolic Acid.—It is not surprising to those who have kept pace with the progress of antiseptics to hear Sir Joseph Lister, after twenty years of investigation and experiment, declare his renewed allegiance to carbolic acid, as he did in a lecture January, 1893, at King's College Hospital, in London. (Annals of Surgery, June, 1893.)

Carbolic acid is not only a more efficient surgical germicide than corrosive sublimate, but it is much more efficient in cleansing the skin. It has a powerful affinity for the epidermis, penetrating deeply into its substances and it mingles with fatty materials in any proportion. Corrosive sublimate, on the other hand, cannot penetrate in the slightest degree into anything greasy; whence those who use it require elaborate precautions in the way of cleansing the skin. All of this is unnecessary with carbolic lotion. Sir Joseph does not even use soap and water trusting entirely to the carbolic acid.

There is a new product of phenol and boracic acid in which has been mitigated the pungency of carbolic acid, disguising its odor and greatly supplementing its efficiency by its combination with boracic acid, which, although admittedly slower in its action, its nevertheless unsurpassed as a true germicide.

Antikamnia.—S. H. Gregory, M. D., New York City, says under date of May 10th, 1893: "I would state I use antikamnia with success in headaches, rheumatism and neuralgia, in combination with citrate of caffeine; also elixir of guarana; with salicylic acid or salicylic of soda in acute rheumatism, and with pulv. guaiac and nitrate of potash to allay the pains of chronic rheumatism."

Phytoline in Obesity.—Dr. Thompson reports the following:

Case.—Mr. N., æt. 54, weight 240, height 5 feet 10 inches, complained of eczema of the legs and left side. Inspection showed in the left hypochondrium, a large circumscribed ulceration about two inches in diameter, surrounded by inflamed vesicular area; the legs showed similar ulceration in the skin. Patient perspired freely, almost to a point of hyperidrosis. During cold weather patient was not troubled except from difficult locomotion and occasional attacks of rheumatism. Examination of urine showed no sugar. Appetite fair, drank considerable beer, bowels regular. Astringent salves and lotions cured temporarily. Diagnosed eczema, due to maceration. Placed patient on Phytolacca (Phytoline Walker's) gtt. xxv. before and after each meal. In two weeks patient lost ten pounds, had somewhat less appetite, less perspiration, sores took on a healthier condition, and after continuing the treatment about two months and a half, patient felt as well as ever, and tipped the beam at 200. Since then the patient has gained but little if any, perspires normally and has no return of his eczema and no recurrence of rheumatism. How long this condition will last time alone can tell.

This last case was one especially calling for some fat reducing agent, and the checking of perspiration. In this case bread and potatoes were prohibited, likewise other form of starchy foods; beer was reduced in quantity, two-thirds. These measures materially increased the fat reducing properties of the phytoline.

The next question is how does phytoline cause the reduction of fat? This, I am at present unable to say. I have, however, noticed that the fæces seemed to be considerably more rich in fatty materials than in normal, which condition cannot be attributed to indigestion, as in all other respects digestion was normal. Perspiration and urine was apparently unchanged by the action of the drug.

Officinal preparation of the root have been used with little or no result, except to cause continued nausea, vomiting and diarrhœa. Phytoline does not cause nausea in the ordinary dose, and though slight laxative effects have been observed from it, I have never seen a pronounced case of diarrhœa. The appetite is sometimes slightly diminished, chiefly in the morning. It seems to me to be specially indicated in all diseases characterized by fatty degeneration of internal viscera, especially of the heart and liver. Those who choose to use it for its cosmetic effects in reducing fat will also find in it a serviceable adjunct to properly restricted diet and exercise.

LEVULOSE IN DIABETES.—Sugar and sugar-forming food constitutes more than half of the nourishment a healthy person needs. When we feed diabetic patients on fat and albuminoid food only, we therefore force him to live on his own bone and flesh, from which the system is forced to draw for its needed supply of carbohydrates.

It is well known that pure meat diet carries with it the great danger of inducing diabetic coma and it is therefore the imperative duty of the physician to furnish his patient with a moderate amount of sugar and sugar-forming food. At the same time, in order to provide for an ample excretion of the circulating sugar, Prof. Leyden suggests to encourage the patient to imbibe a sufficient quantity of liquids.

Such therapeutic measures also tend to avert another fatal danger, viz.,death from sheer inanition. It is evident that a diabetic who cannot supply to his system the substances necessary to maintain his strength and to keep the tissues from wasting away, must eventually go on to complete dissolution. Therefore, Prof. Leyden maintains, *that the prime indication is to feed diabetic patients well, in order to prevent progressive emaciation.*

The excellent advice which he gives in this respect, as to the quantity and quality of the food to be prescribed, it would lead too far to detail here. But in the light of the fundamental principle, thus laid down by this great clinician, it is evident of what great value LEVULOSE (Diabetin) must be in diabetes, since sugar and sugar forming food must be partaken of to a certain extent by these patients.

The name of Diabetin to this Levulose was given by E. Schering, because its main therapeutic use is that of a substitute for cane sugar in the regimen of patients suffering from diabetes.

Diabetin is supplied in 1-lb. screw-top glass jars.

SCHERING & GLATZ,
55 Maiden Lane, New York City.
Sole Agents for the United States and Canada.

ANNOUNCEMENTS.

Notice.

An Army Medical Board will be in session at Washington City, D. C., during October, 1893, for the examination of candidates for appointment to the Medical Corps of the United States Army, to fill existing vacancies.

Persons desiring to present themselves for examination by the board will make application to the Secretary of War, before September 15, 1893, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidate must be between 22 and 28 years of age, and a graduate from a regular medical college, as evidence of which, his diploma must be submitted to the board.

Further information regarding the examinations may be obtained by addressing the Surgeon-General U. S. Army, Washington, D. C.

GEO. M. STERNBERG,
Surgeon-General U. S. Army.

MISCELLANEOUS.

THE GOOD THAT NEW REMEDIES ACHIEVE.—Dr. Cyrus Edson, in the *North American Review*, reminds those who prematurely pride themselves on the virtues of some new remedy, that all new remedies do good—for a time; the physician who persuades his patient of the virtues of his means has half cured him already.

A successful physician is well convinced of the beneficence of his own work, and rightly so, says Dr. Edson ; in this the physician is not wrong, but he is sometimes mistaken in his inference that his success lies in the matter of his prescriptions.

A cheery, hopeful assurance buoys up the sinking life, and, as the dominant "fad" of the moment inspires both doctor and patient, the orbit of function under this inspiration lurches round again toward its proper equilibrium. The sick man who "gives in" dies ; he who has faith and confidence recovers.—*Med. Age.*

POSTPONEMENT OF THE INTERNATIONAL MEDICAL CONGRESS.—We have a cablegram to the effect that the meeting of the International Congress which was to have been held at Naples in September, has been postponed for the present on account of the prevalence of cholera in Italy. Unless there shall be reasons for its further postponement the congress will probably convene at the same city in April next. This will be a serious disappointment to many who had planned to be present at this meeting. In the meantime the Pan-American congress will convene at Washington, and will attract a large number of distinguished men from all parts of the American continent. It will gladly welcome to Washington those from foreign countries, who had planned to visit Naples. The congress itself will be the attraction. The capital city of America will give them a royal welcome, and the "White City" at Chicago will richly repay an ocean voyage.—*N. A. Practitioner.*

ON CONSANGUINITY IN MARRIAGE.—Consanguinity in marriage is still a much debated topic. A great number of physicians are opposed to unions of this kind. Yet consanguinity being only a special case of heredity, it is generally held nowadays that if husband and wife, as well as their ascendants, are of healthy mind and body, the result will be good; in the opposite case it will be bad. Regnault is of opinion that not only the descent of husband and wife produce a consanguinity, but also their sojourn under the same conditions, while on the other hand it may happen that relatives living separated by space should cease to be regarded as consanguineous, being able to intermarry without the character of consanguinity. It has been pointed out that in most nations severe laws have been enacted against marriages between relatives. Regnault on the strength of his investigations thinks that the nations have endeavored with at least equal energy to prevent intermar-

riage between individuals living in the same place without being relatives, *i. e.*, topographic commingling. As instances, the author quotes the Indians of North America and the Australians who used to get their wives far away from their own tribal district. In France, and probably elsewhere, it has been noticed that the strict observance of the religious prohibition of marriage between relatives decreases in the same proportion as the number of marriages between individuals of the same locality. The latter decrease is connected with the increasing facility of transportation. In the middle ages marriages were prohibited between relatives even in the seventh degree, and kings themselves obeyed this law. In the last century the church limited her prohibition down to the fourth degree, and in the present century cousin-germans are allowed to contract matrimony, although with special dispensation. The author explains this disappearance of the laws against marriages between consanguineous persons by the fact that by the progressive and unceasing commingling of individuals, topographic consanguinity came to an end by itself. In France there are some localities constituting an exception to the rule, such as Pollel, Boury de Batz, Fort Modyk, where marriages are strictly limited to the people of the same place. At Orthez where this rule existed among the Protestants, epilepsy had become endemic and inevitable to such a degree, that each house contained a special room provided for it. After the railroads had led to intermarriage with Protestants of other localities, epilepsy has decreased in a surprising manner. Observation of the same kind have been made in animals long ago, and Cornevin quotes a striking instance of this fact. Darwin points to the habit of agriculturists who, for the purpose of improving the quality of crops will always employ seeds from other localities. The fact that consanguinity in a marriage between two persons having lived in different localities is of minor importance, should determine a physician consulted about the opportunity of a marriage between relatives, not only to consider the blood relation, but also the topographic circumstances. Provided both parties are strong, healthy and without taint, any possible objection to their union will be lessened by their not having been raised in the same locality and under the same conditions.—*Bulletin Record.—Pacific Record.*

"First Night" Lesions in Ukraine. — In the *Vratch*, No. 20, 1893, p. 590, Dr. Ivan I. Simonovitch, of Kozeletz Ukraine, (or "Malorossya," *i. e.* "Little Russia"), relates the following case, which, very likely, will appear rather "extraordinary" to an American reader, but hardly so to a Russian practitioner.

On April 16th, a young peasant woman was admitted to the local Zemskaia Bolnitza with complaint of persistent incontinence of urine of two months' standing, her bladder being completely emptied on walking. An inquiry elicited that the patient had married a peasant of twenty-four about two months previously. According to a revolting custom prevailing among the Ukraine peasantry the couple were obliged to pass their "first night" in the presence of several eyewitnesses (best men, Russ. *shafers* or *drushkos* whose duties include that of personally elucidating the fact whether the bride is "innocent" or otherwise). For some reason or other—whether under the influence of spirits, or under that of such a peculiar *mise-en-scéne*, the bridegroom's first attempt at coition failed altogether, in view of which circumstance (and again according to popular custom) one of the "best men" was delegated to destroy the unhappy girl's hymen by means of his forefinger. The delegate, however, missed the vagina and got into the urethra. An abundant hæmorrhage ensued to last for a week. On examination the author found that both the urethra and anterior vaginal wall were ruptured, the rent being four centimeters long. The wound was sutured in the usual way, and in due time the woman was discharged cured.

Dr. Simonovitch's paper has induced Dr. Vladimir V. Tokarenko, of Ostapievo, Poltava government, to publish (*Vratch*, No. 23, 1893, p. 675), a similar case from his own recent practice. A peasant woman, aged eighteen, married two days previously, was brought to his infirmary, with sloughs on the left minor and major labia, and multiple erosions of the mucous membrane of the right nympha, as well as about the vaginal inlet generally. The hymen, which was of the annular variety, proved to be intact, but its lower section was found to be completely torn off from the whole periphery of the navicular fossa. The inquiry showed that the bridegroom, a lad of eighteen entertaining some doubt concerning his virile potence, and following a "best man's" advice, had attempted to lacerate the hymen with his forefinger, wrapped in the bride's coarse canvas chemise. A profuse bleeding resulting, the couple's relatives tried to stop it, first by application of snuff tobacco and then by red-hot iron, which samaritan aid caused the aforementioned sloughing. The sloughs were removed and on the 15th day the girl left with all the lesions healed. No disfigurements whatever were said to remain.—*St. Louis Med. and Surg. Jour.*

To Get Rid of the Odor of Iodoform.—Dr. W. Washburn, of this city, writes *apropos* of a recent item on the deodorizing of iodoform: "In the *Medical Summary* for June, 1893, an article by myself gives an easier and more convenient method. It is there stated that both ether and chloroform are solvents of iodoform, and will remove every trace of it and its odor if the hands are washed with a trifle after washing with soap and water. The hands have a peculiarly clean feeling after using chloroform, dry instantly, and require no further washing. As nearly every physician carries ether or chloroform in his satchel, and as turpentine would be an additional burden, there is this also in favor of these drugs, they are always at hand. When clothing has been saturated with iodoform the proper thing is to first apply chloroform to the spot and rub it in, then wash with castile soap and water, and finally apply chloroform—or ether will do as well if chloroform is not in hand. Any seams coming within the space to be cleaned will require careful attention, just as the nails will if the hands are to be deodorized. The proper way for the nails is to dip a bit of soft wood (a match whittled flat is handy and efficient), in chloroform and with this clean under the nails. I have derived great comfort from applying this method in daily practice."—*Medical Record.*

The Ten-Minute Paper.—The ten-minute paper has recently become, (*New York Medical Journal*), a marked feature in the work of the New York Academy of Medicine. The result has been a

marked increase in the attendance at the meetings, a large number of concise, pithy, and interesting papers, and a wide publication of the proceedings. The instructions to writers of papers formulated by the chairman contained a number of apt suggestions and were somewhat as follows: 1. Hippocrates and Galen may be passed with very slight notice, as they have been for some time dead and their opinions are somewhat obsolete. 2. Scratch out the formal introduction and begin where the subject matter really begins. 3. Condense the body of the paper. 4. End the paper where the subject matter ends, making its action like that of the piston syringe—begin, spatter, stop. Will gentlemen now preparing papers for the Ontario Medical Association take note of the above? —*Med. Age.*

An Interesting Experiment.—M. d'Arsonval, the colleague of the eminent physiologist Brown-Séquard, has just tried before several scientific gentlemen a very strange experiment. At his invitation, two members of the Académie des Sciences, MM. Cornu and Marey, entered into a large wooden cylinder around which was rolled copper wire. When these gentlemen were seated inside M. d'Ansonval sent through the wire a series of very rapid and powerful electric currents. At the end of some minutes the "patients" said they felt no inconvenience, save that they felt the necessity of breathing more deeply; yet according to scientific law they should have found themselves plunged in an electric bath which would have instantly killed them if the operator had not taken the precaution to change continually the direction of the currents. To prove that the laws of science as known were not in fault, M. d'Ansonval invited the two gentlemen to take in their hands incandescent lamps, isolated completely from any wire. Hardly were they in the hands of the "subjects" when they lighted up as if they had been really attached to some powerful battery. To prove still further the intensity of electric currents capable of being borne by a man without danger, he gave them as many lamps as their hands could hold, and thus the two *savants* were transformed into six-branch candelabra. The experiment of the disciple of M. Brown-Séquard proves conclusively that man can live at ease in an atmosphere loaded with electricity. The importance of the fact cannot escape notice, as it puts scientists on the trail of that magnetic influence which some persons appear to possess and put to unfair advantages. Dr. Luys, one of the most ardent believers in hypnotism, has explained, in a manner satisfactory to himself at least, the resemblance between the two fluids; by means of a magnet he transmits the sensations and malaises of one patient to another. The study of the phenomena is interesting from the fact that what is already known so mysterious and so confusing may become later on comprehensive realities.—*Med. Press and Circular.*—*Jour. of Baln.*

The Value of Boiled Milk.—Dr. Drouet, in his work "De la Valeur et des Effets du Lait bouilli et du Lait cru dans l'Allaitement artificiel," which has been awarded the Prix de l'Hygiene de l'Enfance in the Academy of Medicine, summarizes his conclusions as follows: Although some children undoubtedly digest unboiled better than boiled milk, milk does not become less digestible by boiling. The nutritive proprieties of boiled milk are amply sufficient to nourish young children. Boiled milk keeps fresh a longer time than unboiled. Dr. Fayel considers boiled milk hurtful to children, and does not believe that the germs are destroyed by boiling. The tubercle bacillus is killed only at a temperature of 110° to 120° C. Experiments made at his laboratory at the Physiological Institute show that the degree of ebullition never exceeds 100° C. Dr. Fayel also says that tuberculosis does not increase infantile mortality. Children die from enteritis, and boiled milk, it is to be feared, might encourage this affection.—*Brit. Med. Jour.*—*Jour. of Bal.*

Expose of Quack "Chemical Compounds."—A large proportion of the recently introduced antipyretics and antiseptics, though almost in every instance advertised to be a "chemical compound," have been found to be simple *mixtures* of several medicinal chemicals, combined in varying proportions. Thus, "*anticol*" is a proprietary article introduced to the world as the "sovereignest thing" for febrile affections. It has been unmasked, and is found to consist of 75 per cent of antifebrin, 17.5 per cent of sodium bicarbonate, and 7.5 per cent of tartaric acid. "*Anticylic acid,*" introduced as an antipyretic and anodyne, is reported to be merely a mixture of *anti*pyrine and sali*cylic* acid. "*Antidiphtherin*" is a name given to a new preparation claimed to be a remedy for diphtheria, and which, upon examination, is found to contain potassium chlorate and a trace of ferric chloride. "*Antikamnia,*" is a compound foistered upon the medical profession as an anodyne, but which, according to analysis, is merely a mixture 70 parts of antifebrin, 4 of caffeine, and 22 of a mixture of sodium bicarbonate and tartaric acid. "*Antinervin*" (so-called "salicyl-brom-anilide"), lauded as an anodyne and nervine, consists, according to E. Ritsert, of a mixture of one part of ammonium bromide, one of salicylic acid and two of antifebrin. "*Antiseptin*" (so-called "zinc borothymol-iodide"), extolled as an antiseptic, is, according to Goldmann, a mixture of 85 parts of zinc sulphate, 2½ of zinc iodide, 2½ of thymol, and 10 of boric acid; it must not be confounded with "antisep*sin*," which is chemically para-mono-brom-phenyl-acet-amide, nor with "antisep*tol*," which is cinchonine iodo-sulphate. "*Aseptin,*" an antiseptic introduced some years ago by Gahn, is said to consist of a mixture of boric acid, borax and alum. "*Camphol*" is an antiseptic and anodyne consisting of a mixture of camphor and salol in varying proportions. "*Exodyne*" is another antipyretic and anodyne, which, according to F. Goldmann, is nothing but a mixture of 90 parts of antifebrin, 5 of sodium salicylate, and 5 of sodium bicarbonate. "*Lysol*" is a disinfectant of very complex and indefinite chemical composition. "*Phenolid*" is an antipyretic and anodyne found by analysis to be a mixture of 58 parts of antifebrin and 42 of sodium salicylate. "*Quickine*" is an antiseptic composed, according to the *Pharmaceutische Zeitung*, of one part of corrosive sublimate, 50 of carbolic acid, and 50,000 of dilute alcohol. "*Somnal,*" introduced as a hypnotic, is reported to be merely a solution of chloral and urethane in alcohol.—*Merck's Report.*

Should Inebriates Suffer the Death Penalty for Crime Committed While Intoxicated. — In a paper before the Section on Medical Jurisprudence of the Pan-American Medical Congress in Washing

ton, Sept. 5-8, Dr. T. D. Crothers, of Hartford, Conn., gives the following reasons why criminals should not suffer the death penalty for crimes committed while intoxicated:

"From a scientific study of these cases it is clearly apparent that they are diseased and incapaciated to act sanely. Alcohol has palsied the brain and made them madmen.

"The very fact of the continuous use of alcohol is evidence of mental impairment and unreasoning act and thought.

"The death penalty is followed by an increase rather than a diminution of crime.

"The object of the State, through the law, is to protect society and the individual; but if the execution of the law-breaker fails to accomplish this end, the laws are wrong.

"The inebriate should never be hung for crime committed while under the influence of alcohol, but should be confined for life in a military workhouse hospital under the care of others, as one incapaciated to enjoy liberty, and incompetent to direct his thoughts or acts."—*Times and Register.*

DEATH FROM SALOL.—At a meeting of the Biological Society of Paris, held the 27th of May, M. Girode exhibited two lumps of salol weighing 1.55 grammes and 1.25 grammes, which had remained undissolved in the stomach of a woman for twelve months.

The woman died on the 20th of April in the Beaujon Hospital, and when the autopsy was being made the injected condition of the great curvature of the stomach attracted attention, and when the viscus was opened the two masses of salol were found.—(*L'Union Medicale*, No. 64.)

WIT AND HUMOR.

THE GERMAN PROFESSOR ON HYPNOTISM,—"Hybnodism," the German professor said thoughtfully, "vos a mendal disorder dot vos raging brincipally in der noosebapers. It vos a hypertrophy auf der imachination, undt der writers on mendal pheenomenon vos first attacked. You migd call it a sort auf writer's cramp auf der prain. Der ingrediences peen made auf a fool undt a rascal. Mix thoroughly undt set avay in a cool blace. Bud one authenticated case has been reborted undt dot vos told py a notorious liar auf France. As a defence for der lawyers to set up in murder trials it vould peen a pudding, as Schiller saidt; bud its brincipal use so far alreaty has peen confined to sheap novels undt skyentific makezines. Fife tousand years ago a Greek philosopher hybnodized a rooster chicken mit a straight chalk-mark on der floor, undt now, in 1893, der skyentific beeples discofer dot you can hybnodize beeples auf dey aint got as much prains as dot rooster. Nature got hard feelings toward a vacuum, undt auf you got no intelligence auf your own you can absorp dot from somepody else. It vos a choyful surbrise to some beeple's heads to get a mind inside auf dem py hypnodism auf dey didn't had some alreaty py natural. It's bedder, young mens, dot you cultivate some prains auf your own, aber you debend on hybnodism aber hybnodermic inchections auf mendalidy. In der meandimes I can hybnodize dis class more expeditiously undt skimultaneously mit a glub. It's bedder you enchoy dis pecooliar phenomenons while she is goin', pecause she vill soon go down der stream auf time pehind der plue glass, der roller skate, Koch's lymph, Keeley's gold cure, undt pig-headed canes. You can now go der door outside undt blay ball mit you feet.—*Judge.*

The menu card at a pharmaceutical banquet read as follows:

Nothing too Good for Us

B

SOUP.

Assafœtida. Bouillon. Quassia.

RELISHES.

Cayenne Pods. Young Garlic. Cocoa Butter.
Plaster Paris Bread.

FISH.

Cuttle Fish, Fresh (from Salt Lake). A La Aqua Calcis.
Catfish with Spts. Turpentine. Fried Leeches with Dragon Blood Sauce.

ENTREES.

Fillet of Beef. Castor Oil Gravy. Citrate Caffein.
Giblets.

ROASTS.

Young Turkey (patented) with Balsam Copaiba. Veal with Uva Ursi Leaves. Shrimp Salad with Iodoform Dressing.

VEGETABLES.

Pumpkin Seed. Vanilla Beans. Mullein. Corn Salve.
Potatoes Stewed in Oil Tigili.

DESSERTS.

English Plumbi Pudding. Mucilage Acacia Sauce. Salt. Water Ices. Cakes of Soap, assorted. Ladies' Fingers with Cots. Chocolate Quinine. Sage. Pennyroyal. Senna Tea. Coffee with Chalk and Sugar of Milk. Carbolized Cream. Cheese "It."

Finger Bowls with Bichloride of Mercury, 1-100. *Rubber Napkins*

"Oh! What a Difference in the Morning."
—Meyer Bros. Druggist.

THEY had asked Dr. Sandblast, the eminent surgeon, to carve the festal fowl, and he stood over it with the carving knife held delicately in the first position. "The incision, you will observe, gentlemen," he began dreamily, "commences a little to the left of the median line, and—oh, excuse me, Mrs. Parmalee, I thought I was in the—*may* I help you to a little of the femur?"—*Puck.*

PRESENCE OF MIND.—The morning after the recent snow storm a big policeman walked into the W. R. U. and said: "Too much snow in front of your building. Who looks after the paths?" "They will be attended to," answered a quick-witted student, "just as soon as the pathology professor gets here." "All right," said the blue-coat, and walked away perfectly satisfied.

A well-known doctor of this city, who has a very prominent abdomen, recently confined a lady, and in a day or so the following conversation was overheard: First little girl: "Where did you get your baby?" Second little girl: "Dr. ——— gave it to us." First little girl: "Oh! has he got babies?" Second little girl: "Oh, yes; he's just full of 'em.—*Gross Medical College Bulletin.*

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

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ORIGINAL ARTICLES.

How Does the Young, Unmarried Girl Get Genital Disease, and How Shall We Treat Her?

F. BYRON ROBINSON, CHICAGO.

The center and circumference of gynæcology are not the scalpel. Much of gynæcology is not surgical. There is a class of girls who puzzle to know just how to treat them. They range from fifteen to twenty years of age. In this class of girls I mean to exclude the idea of gonorrhœa. But on examination bimanually one finds various pathological factors. In some, one finds the posterior or sacro-uterine ligaments contracted, thickened and tense on one or both sides. In some this is all that can be detected. In others, in addition to sacro-uterine thickening and shortening, we find that the uterus is curved on itself or flexed over the bladder and is abnormally stabile. It is fixed in its flexion. A uterine catarrh (leucorrhœa) exists and the body of the uterus is much harder than normal. She has dysmenorrhœa so severe that the so-called aggressive gynæcologist just home from college wants to remove her appendages so that he can save her from speedy insanity. Other girls may be found with the uterus drawn to one side (generally the left) by a distinct band stretching from about the cervix toward the pelvic wall. More and more careful study and observation of these poor girls has lead me to more definite views. By studying the cases of such girls one may learn very much, especially if it be in the direction of a rational pathology. In the first place we notice definite factors. 1. A displaced uterus. I mean by a displaced uterus one permanently out of its normal position. 2. Generally anteflexion. I mean by anteflexion, a uterus flexed forward over the bladder and possessed with abnormal stability. 3. Dysmenorrhœa. 4 Endometritis (leucorrhœa). 5. Metritis, a hard, enlarged uterus which has lost its flexibility. 6. Very frequently a thickening and contraction of the sacro-uterine ligaments exist. In the above factors we have then a rational explanation by pathology of the symptoms.

1. How did the uterus get displaced? The sacro-uterine ligaments became affected with an inflammatory process. The result was contraction. When these ligaments contracted the cervix was drawn upward and backward so that the fundus was tilted forward. But the first story to settle is how did the endometritis arise? What induced the uterine catarrh or leucorrhœa? This is not easy to settle, but in the present cases gonorrhœa should not be brought in. In the first stage I might say that I think the endometritis is due to infection. The infection must get to the endometrium either through the vagina, or as Dr. J. B. Bacon, of Chicago, insists, it may pass from the rectum into these uterine ligaments. If it pass through the vagina it may be accounted for by the dust of the roads, the manipulations of the vagina by the fingers, or infection may pass up at the time of the menstrual flow.

According to Bacon's view the infection may pass through some rectal abrasion. The infection passes into its parametric tissue from the rectum and induces inflammation and subsequent contraction of the ligaments. Dr. Bacon informs me that the abrasions in the rectum are not uncommon. The final results are contraction of the sacro-rectal ligaments which drag the cervix upward and backward, and tilt the body forward.

Young women suffer very much from the diseased ligaments in constipation. The reflex symptoms increase in extent and intensity until defecation is dreaded. In the case of the endometritis of course of some infective origin, stagnation of secretions make matters worse by absorption. The uterine catarrh or endometritis persists and gets worse until it induces a metritis, slow and persistent. Now we can explain the dysmenorrhœa which is not of a mechanical origin, but is due to the over filling of the uterine vessels. The over filled vessels are painful because they press on the terminal nerve filaments. Just as soon as the flow starts the pain ceases, which is a strong point for over filled vessels being the cause.

Such young women suffer from bladder trouble from the dragging on the bladder and thus irritating its nerves. When the distended vessels are depleted and the flow starts, the pain ceases. Such girls have very poor drainage both from uterus and rectum (constipation).

Now, what shall we do for such cases. They suffer much before they ever come near a doctor.

1. Such girls should be treated with douches before being examined. To examine a young girl breaks the thin veil that hangs between morality and immorality. The douche should be first a half pint of tepid water out of a fountain syringe. The amount of water and the heat should be daily increased. In about ten days the girl should be taking four quarts once a day, with a handful of table salt and a teaspoonful of alum. The water must be hot as she can bear it, and she should require fifteen to twenty minutes to take the douche. If after a few weeks of such treatment, improvement does not occur, she should be examined, and glycerine tampons also employed with morning and evening douche.

2. The uterus may be dilated to attempt to cure the endometritis by drainage. This is a simple procedure, but not generally very successful.

3. The uterus should be curetted well. It should be slowly (six minutes) dilated and vigorously scraped. Then a sound wound in cotton and dipped in pure carbolic acid should be passed into the uterine cavity and carefully applied to the whole endometrium once or twice. The constipation should be relieved. A full glass of water drank at bedtime may be sufficient if she will go regular to stool after breakfast, when the hot coffee has induced peristalsis of the digestive tract. A good tonic of iron, gentian, and nux vomica will do good work.

4. Electricity sometimes does good work in endometritis. It may be tried. Many girls suffer from the pathological train, endometritis, metritis, dysmenorrhœa, contraction of the uterine ligaments due to inflammation, and resulting in displacements. The treatment of such girls is a delicate matter, and the troubles are difficult to cure. But they are not cases for removal of the appendages.

Western Medical Reporter.

A Monthly Epitome of Medical Progress.

JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

The Greatest Heritage—An Honored Name.

Under this caption the *Denver Medical Times* pays its respects to Dr. Hammond, and the *N. Y. Medical Journal* in the following:

After something like thirty years of forgetfulness, the great medical public again is called to consider the personal and professional attributes of Dr. Wm. A. Hammond, who has become involved in another unsavory quarrel. It would seem to an unbiased observer that the accumulation of an extra million of dollars would hardly repay a man for undergoing the castigation to which the *American Lancet* has recently subjected the doctor. And then, when we recollect that after this life comes—"the eye of the needle!"

So far as the general profession is concerned, we do not believe that very many have been humbugged, but our grievance is as much against Frank P. Foster, of the *New York Medical Journal*, as any one else. We have a right to expect from such a journal and such an editor the professional fair play that will protect the profession from "fake" scientific articles, or if published by any oversight, we have a right to an apology. Instead, we find the columns of that journal being used in an attempt to divert criticism by assailing the character of Mr. Ernest Hart. Shame on you, Dr. Frank P. Foster! Shame on you, Dr. William A. Hammond! Be men. You have put your foot in it, and every one knows it. Make an open acknowledgment of error--a free and frank apology, and try to regain the esteem of your fellow-men, instead of endeavoring to divert attention by "calling the kettle black."

The editors of the *Denver Medical Times* owe to their readers and to themselves the duty of stating publicly that they received from some unknown source type-written copies of Dr. Hammond's original articles on "Animal Extracts" and on "A New System of Ventilation," before either article had appeared in the *New York Medical Journal*, and that after perusing them and detecting their actuating motives, we consigned them to their proper destination—the waste basket.

DR. WILLIAM E. QUINE.

Dr. William E. Quine.

The subject of this sketch was born in the Isle of Man, February 9th, 1847, and removed with his parents to Chicago six years later. He was educated in the public schools and is a graduate of the West Side high school. After leaving school he devoted himself to the study of pharmacy and materia medica. Later he entered the Chicago Medical College, from which he was graduated in 1869. Immediately after taking his degree he was elected to the professorship of materia medica in his Alma Mater, but as he had also been appointed an *interne* in Cook County Hospital he did not enter upon the discharge of his professional duties till 1870. His hospital service was of so distinguished a character that at its close the medical board appointed him gynecologist and obstetrician to the hospital, which position he filled for ten years with credit to himself and advantage to the institution.

In 1885 he resigned his chair in the Chicago Medical College to enter upon more congenial duties as professor of the Theory and Practice of Medicine in the College of Physicians and Surgeons. This position he still fills and fills admirably. His natural eloquence, profound knowledge and painstaking methods place him among the leading teachers and practitioners. He is now president of the College of Physicians and Surgeons, and a member of the American Medical Association, the Illinois State Medical Society, the Chicago Medical Society and the Medico-Legal Society. He has been a frequent contributor to medical literature and has in preparation an exhaustive work on the Practice of Medicine. In 1874 Dr. Quine was married to Miss Lettie Mason, of Normal, Ill., a lady of great natural ability and broad culture, whose rare qualities were demonstrated by her work as a medical missionary to China.

RECTAL ALIMENTATION.—Huber has recently shown by actual experimentation, that from fifty-eight per cent to seventy per cent of fluid egg albumen may be absorbed from the rectum without peptonization. A slightly larger proportion of albumen was absorbed after peptonization, but less than half as much when chloride of sodium was not added. The proportion of salt found necessary to stimulate absorption, was one gramme, or one-fourth of a drachm for each egg.—*Mod. Med. and Bact. World.*

Abstracts.

Medicine.

Diarrhœa Caused by Infusoria.—Of the four cases reported by Dr. Roos, of Kiel, of persistent diarrhœa, the first was due to megastoma entericum and trichomonas intestinalis; the second was caused by balantidium coli; the third by cercomanos homanis; the fourth was produced by a moderately large infusoria which has not yet been described, but could be compared to the oxyuris in form.

The fifth case of intestinal catarrh was complicated with retarded action of the intestines; there were found besides the trichomonas intestinalis and megastoma, those described by R. May. After the continued and regular doses of calomel, the infusoria were killed and the intestinal catarrh cured.

The author does not consider the infusoria as a direct cause of the intestinal catarrh, but feels that they are, in a measure, the cause of the long duration of the diarrhœas.—*Med. and Surg. Rep.*

Rumination in Man and its Relation to the Act of Vomiting.—Dr. Singer, Vienna, says: The observations upon four ruminants resulted in the following conclusions:

Rumination is the expression of a nervous constitution. The further cause of the act is a relative insufficiency of the cardiac orifice of the stomach, which often opens at a time when a certain amount is contained in the organ. The mechanism of the act consists in aspiration of the contents of the stomach, in the presence of a relaxed cardia and a decrease of air in the thorax, which is produced by the act of inspiration, filling the thorax and at the same time closing the glottis; rumination can be repressed by expiration.

Physiologically and clinically this should be regarded as separate and distinct from the ordinary act of vomiting. The gastric function is inconstant and only of passing importance; the anomalous secretions of the stomach are due to neurotic conditions and require, therapeutically, only symptomatic treatment, while the *cause* of the neurosis is receiving the proper attention.—*Med. and Surg. Rep.*

The Pathogenesis of Hepatic Abscess.—Zancarol (*Revue de Chirugie*, August, 1893) states that he has proved by experiments on animals that dysentery and hepatic abscess are affections of the same nature, and that the pathogenetic factor of this complex organism is a microörganism. A clinical experience of twenty-five years has convinced this author that the pus of a hepatic abscess is not less deleterious than that of other suppurating organs, and, also, that dysenteric and hepatic abscess are closely associated, so that, though one may not be the cause of the other, both affections are produced by the same toxic agent. In order to establish these conclusions on a scientific basis, Zancarol instituted a series of experiments on cats, the results of which show that both dysentery and abscess of the liver can be transmitted from man to these animals by injections of the pus and intestinal excretions, and that histologically the lesions in the human subject and those artificially produced in the animals are of a like nature. Hepatic abscess, it is asserted, has microscopic origin, the principal factor being the streptococcus. It remains to be settled by future inquiry whether other organisms apart from the streptococcus are capable of producing a similar morbid condition, or whether this organism is the special originating agent of the hepatic affection. Dysentery is regarded as an affection of the same nature as hepatic abscess, its pathogenetic agent being the streptococcus. As to the amœbæ which are so often met with in the fæcal discharges even of healthy individuals, these organisms, the author holds, play no part in the causation of dysentery and hepatic abscess. The streptococcus in most instances passes from the intestine to the liver either by the portal vein or the general circulation.—*Brit. Med. Jour.*

The Eruption of Dengue.—This was the subject of a communication to the Academy of Medicine by M. de Brun, of Beyrouth. The author stated that the eruption might simulate that of scarlet fever, measles, or rötheln. It generally consists of small and closely aggregated papules, sometimes followed by desquamation and severe itching. The eruptive forms of the disease may be divided into three varieties.

1. The fibrile eruptive form. It is distinguished from other eruptive fevers by the following characteristics: The rash is not constant and it does not appear at a determinate period of the malady; the development of the eruption has no influence upon the other symptoms; the severity of the disease bears no resemblance to the abundance of the eruption.

2. The apyretic eruptive form. This is very common. It is marked by a partial or generalized eruption, of variable violence, coinciding with the other symptoms of dengue (headache, prostration, contracture, etc.), without the occurrence of fever.

3. The exclusively eruptive form, in which the rash is the only manifestation of the disease.

The diagnosis of the eruptive forms of dengue is sometimes very difficult. The febrile form is easily differentiated from scarlatina and measles, but is sometimes distinguished with difficulty from smallpox and typhus fever when the three epidemics prevail at the same time, as occurred at Beyrouth in the months of November and December, 1892. The measles-like eruption of dengue differs from that of epidemic influenza by the following features: 1. It affects no special disposition. 2. It does not begin particularly upon the face, upper extremities, or trunk. 3. There is never a concomitant catarrh of the air passages. 4. The eruption rarely occurs at the beginning of the fever. 5. It is nearly always followed by itching and desquamation.

The apyretic forms must be distinguished from drug eruptions, infectious roseola, eruptions caused by the sun's rays, and from urticaria.—*La Tribune Médicale.—Med. Bull.*

Etiology of Acute Articular Rheumatism.—Prof. Sahli, Berne, begins this article by stating that acute articular rheumatism is probably an infectious disease, and mentions Huter as the first who called attention to this fact, presenting some points for this statement. He calls attention to the acute rise in temperature, which is usually an attribute to infectious diseases, and also to the local affection of the joints, in which the resemblance to septic or pyæmic joint affections make the differential diagnosis most

difficult. In addition to this he considers the relations between articular rheumatism with endocarditis and the affections of serous membranes, often present a resemblance to pyæmia. The resemblance becomes still more complete in comparing the case bacteriologically. The granulations on the endocardium, so often present in acute articular rheumatism as well as in pyæmic endocarditis, will show the presence of similar microörganisms.

In addition to this the author reports a case of typical acute articular rheumatism which was complicated by endo- and pericarditis and pleuritic exudations. The history of the case, fully given, reports the result of a careful pathological examination, which showed the presence of staphylococcus pyogenes citreus in the blood of the left heart, in the swollen bronchial glands and in the various exudations of the pericardial and pleuritic cavities.

The author concludes his remarks by stating that the bacteriological investigation of the reported case, proves that the so-called complications of articular rheumatism (endocarditis, pericarditis and pleuritis) belong etiologically to the disease in question and therefore cannot be regarded as complications, but as localizations; and further states that in a number of other cases of acute articular rheumatism a study of the blood and the secretions of the diseased joints proved the presence of staphylococci.—*Med. and Surg. Rep.*

A New Diagnostic Sign of Typhoid Fever.—Among all the cases of typhoid fever which he observed during the course of the last two great epidemics at Odessa, Dr. V. Filipovitch demonstrated the presence of a sign hitherto unannounced, and which he designates by the name of palmo-plantar sign. It consists of a peculiar callous aspect and a yellow, orange, or even saffron color of all the projecting parts of the palms and soles—parts which, in healthy subjects, are more or less rosy, and which become bluish in cases of cyanosis. This phenomenon may be explained by the weakened action of the heart, by the incomplete filling of the capillaries, and the dryness of the skin of typhoid fever patients. As he found the sign constant and well-marked, M. Filipovitch thinks that it may prove of service in those cases, sufficiently frequent, where the usual symptoms are absent at the beginning of the malady. Another Russian physician, Dr. Skibnevsky, has also convinced himself, during the course of an epidemic of typhoid fever which raged in one of the districts of the government of Moscow, of the constancy of the palmo-plantar sign indicated by M. Filipovitch. The manifestation rapidly disappears when the patient becomes convalescent.—*La Revue Médicale.—Med. Bulletin.*

The Tongue in Influenza.—Faisans recently made an interesting communication to the Société Médicale des Hopitaux, concerning the tongue in grip. (*Med. Rec.*) Its special characteristic is an opaline tint of bluish white, sometimes uniformly distributed and again appearing in patches. This porcelain appearance of the tongue is often the first definite sign of grip, and accompanies the vague malaise that precedes the disease. It always appears during the first two or three days. As long as the condition is present, the patient is by no means well, though recovery may be apparent. Complications may arise as long as the opaline tint remains. The tongue is not altered in form or dimensions, nor is it ever dry unless some phlegmonous inflammation is imminent or has already begun. If there is a catarrh of the digestive tract, and the tongue becomes heavily coated, the opaline tint is still visible about the boarders, and may show through the coating in places. Cathartics may help clear up the furred tongue, but its characteristic porcelain effect remains. In pneumonia complicating grip, the tongue dries up without effect upon the opaline tint upon its borders. In a case of supposed meningitis in a child, the peculiar appearance of the tongue served to establish the diagnosis of grip, a diagnosis verified by subsequent events. Sometimes there is lingual desquamation, as in scarlet fever.—*St. L. Med. and Surg. Journal.*

The Morbid Anatomy of Paralysis Agitans.—Recent investigations indicate that paralysis agitans can be taken from the list of "functional" diseases, and placed in that of organic diseases. Dr. C. L. Dana (*Journal Nervous and Mental Diseases*, May, 1893), in a paper read before the Philadelphia Neurological Society, entitled, "A Clinical and Pathological Study of Shaking Palsy, with the Report of Two Autopsies," concludes that there is in the disease a general vaso-motor paralysis affecting skin, viscera, nerves, and lower nerve centers, but not the brain. There was found in two cases examined post-mortem, great vascular dilatation, connective tissue proliferation and nerve cell degeneration. The lesions were most marked in the central gray of the cord, and in the vagus and glosso-pharyngeal nuclei. No changes were found in the brain. Dr. Dana believes the vascular and connective tissue changes to be primary, the nerve cell changes to be secondary. The process resembles a low grade of chronic inflammation. He considers the disease to be of microbic origin, due to a toxine, and that its seat is in the spinal cord, and more particularly in the anterior gray matter supplied by the central arteries. Ketscher, of Prague, (*Neurolog. Centbl.* No. 5, 1893), who has also investigated the subject, reports the post-mortem findings in three cases. Atrophy in varying degrees was present everywhere. The nerve fibers in the cord were almost completely degenerated, this being especially marked in the posterior columns and in the peripheral nerves. There were some changes in the brain, the ganglionic cells being pigmented and somewhat degenerated. Marked vascular changes were found, the vessels being thickened and altered. Miliary aneurisms and small hemorrhages were found in the cord. An examination of the nervous system of ten old persons who had never suffered from paralysis agitans, revealed the same changes in a lesser degree. Prof. Ketscher agrees with Borgherini, and others, that paralysis agitans is nothing more than a premature senility of the nervous system, and he further agrees with Dana that the primary changes are in the vessels, those in the nervous structures being secondary.—*Pitts. Med. Review.*

About Boiled Milk.—In a recent communication to the Société de Médicine de Lyon on the above subject, Crolas (*Lyon Médical*) concludes :

1. That the process of boiling the milk relieves this article of food of small quantities of butter, which, mixed with albumin, is found in the skin that forms over the milk on cooling.

2. That boiling has no action whatever on the caseine or the lactose, these principles remaining the same after as before the boiling.

3. That boiling increases the quantity of the soluble phosphates, this appearing to show that the boiled milk contains a larger amount of phosphoric acid already for assimilation.

Crolas, therefore, believes that boiled milk, as an article of food, is equivalent, if not superior, to non-boiled milk.—*Therapeutic Gazette.*

Some Recently Introduced Reactions to Detect Albumen.—Dr. B. Vas has contributed a careful paper on this subject to the *Ungar. Archiv. f. Medicin.* His main points are:

1. The trichloracetic acid test. To about ½ drachm of filtered urine, 15 drops of a 30 per cent solution of trichloracetic acid are added. If albumen is present, a cloudiness occurs, more or less marked, according as more or less albumen is present. This test will detect albumen when not more than .002 per cent is present. According to Vas, the limit for the test by boiling is .005 per cent. If the urine be rich in urates a cloudiness may occur, but this disappears on warming.

2. The sulphosalicylic test. Vas employed a 20 per cent solution of this substance, of which he added a few drops to the urine. If the albumen present reached .002 per cent in amount, a distinct cloudiness occurred. This test is more delicate than the acetic acid and ferrocyanide of potassium test. The only normal or abnormal substance besides albumen precipitated by sulphosalicylic acid is albumose.

3. The acetic acid and corrosive sublimate test. A few drops of a mixture of 1 part of dilute acetic acid with 6 parts of 1 per cent solution of mercury perchloride are added to the urine, when a cloudiness occurs if albumen be present. This test only shows albumen when it amounts to .06 per cent, and causes a turbidity even when no albumen is present.

4. The acetic acid and sulphocyanate of potassium test. This test solution consists of 100 parts of 10 per cent sulphocyanate solution and 10 parts of dilute acetic acid. A turbidity occurs in urine whose albuminous constituents do not exceed .004 per cent. This re-agent has no effect on any other urinary constituent.

Vas describes several other tests, but considers them inferior to those described. Of these he assigns the first place to sulphosalicylic acid, and the second to the acetic acid and sulphocyanate test.—*Centralblatt f. inn. Med.—Pacif. Med. Jour.*

Clinical and Etiological Observations of Psoriasis.—The author, Dr. Nielson, having studied 927 cases during twenty-five years at Prof. Haslund's Clinic, presents some points of interest. Localization, the palmar and plantar surfaces are more frequently attacked than is generally supposed (19 per cent); punctated affections of the nails (10 per cent); the extremities come next in frequency.

As an average, an attack, under the treatment of large doses of iodide of potassium (50 gm. per day), lasted in twenty-seven adults, 38.7 days; in thirteen children 61.9 days. In cases in which arsenic was used internally with external medications, the attack lasted, as a rule, 52.3 days among nine children. It is probable that the arsenical treatment, given in increasing doses, will produce the same effect as the iodide of potassium.

The diseases runs a thoroughly typical course, lasting in some cases throughout life, having its remissions and exacerbations.

There were forty-nine cases in which remissions occurred at intervals of from one to five years; in ten, five to ten years; in eight, ten to thirty-two years. Generally the disease has no tendency to increase with the age of the patient, even though treatment be left out of the question. Chronic alcoholism or rheumatic joint affections frequently increase the severity of the attack, while intercurrent diseases accompanied by marked changes in nutrition, often act as a curative measure. Exacerbations frequently occur in the spring or fall. The disease occurs oftener in the male than in the female (3:1); is most frequently observed between the ages of five to fifteen, (in about 44 per cent); and after the age of fifty is found in about 2.7 per cent.

In 306 patients there was a distinct hereditary history; twenty-nine per cent showing that the disease existed in the immediate family; in fifteen per cent there was a history of a recent introduction. There is no etiological proof, however, that heredity should be considered of greater importance than contagion.

In isolated cases, psoriasis followed an attack of measles, scarlet and typhus fever, erysipelas and pleuritis, while in chronic affections (carcinoma, diabetes, etc.) it has often disappeared.

Patients suffering from other skin affections (prurigo, ichthyosis, eczema, etc.) are not exempt from psoriasis. Pregnancy in some instances has acted as a cure.

Statistics collected from the larger cities of Europe show that there was in 15,376 cases of skin affections 6.5 per cent psoriasis, and in America 58,617 cases showed only a percentage of 3.28 (J. White).—*Schmidts Jahrb.—Med. and Surg. Reporter.*

Geography of Heart Disease.—According to Dr. E. M. Hale, in an interesting paper recently read by him on this subject, heart disease is more prevalent in New Jersey than in any other State in the Union. It kills more people there in proportion to the population than in any other State. Next to New Jersey comes New York in its rate of mortality from heart disease. In the States north of Mason and Dixon's line the mortality from heart disease far exceeds that in the South. Dr. Hale explains this fact by the difference in the weight of the atmosphere. In New Jersey the air is damp and heavy, and in the other States enumerated the same condition prevails. That this is a general law, the doctor said is proved by the fact that in West Virginia, in the cold and damp atmosphere of the mountains, heart disease is far more prevalent than in old Virginia, where the climate is more even. —*N. Y. Med. Times.*

Money (A.) on a Note on the Diagnosis of Tubercular Meningitis.—Every text-book of medicine refers prominently to the difficulty of diagnosing some cases of tubercular meningitis, but little attention has been drawn to the value of the reflexes. In cases of doubt I believe an appeal to the condition of the reflex actions during the course of the disease will sometimes prove of signal service in the diagnosis. The reflexes are altered in cases of simple inflammatory fever and enteric fever, but the alterations are fairly definite; the knee-jerks are increased, and an ankle clonus may be obtained. The superficial re-

flexes are also increased. The deep reflexes in the arms are apt to be developed or exaggerated if normally present. These changes are usually symmetrical on the two sides of the body. The knee-jerks are never lost in uncomplicated cases of inflammatory or continued fever while the pyrexia lasts.

In meningitis an increase in the activity of the reflexes may be present, and frequently it is found that there is a loss or diminution of some of them. In a doubtful case, in which the diagnosis rests between tubercular meningitis and typhoid fever, the absence of the knee-jerk tells in favor of the former; and this absence is very strong evidence of tubercular meningitis, if the knee-jerk on the other side is exaggerated, or if there is ankle clonus on the same or the other side. I have notes of many cases of tubercular meningitis in which this unusual combination of lost knee-jerk, with fairly marked ankle clonus, obtained. I have never met this combination in a case of enteric fever.

In two other cases of tubercular meningitis, completed by an autopsy, the superficial and deep reflexes on one side of the body have been totally lost, while those on the other side were decidedly exaggerated. In an infant aged fifteen months the side on which the reflexes were exaggerated, subsequently became hemiplegic. This was also the case in a girl aged two and a half, which I saw with Dr. Dagnall Clark, but there was no autopsy. In a case of hemiplegia in an infant aged ten months, reported in the "Clinical Society's Transactions" in 1884, a vascular lesion was found, thrombosis of a branch of the middle cerebral artery complicating the signs of tubercular meningitis.

The case reported by Dr. Shewen in *The Australasian Medical Gazette* for January presented an insensibility of the right side of the body, followed by hemiplegia; the knee-jerk being absent, but a distinct ankle clonus present. It will be noted that in the case referred to above the hemiplegia supervened on that side on which there was a greater sensibility. One observed that raising the left eyelid for ophthalmoscopic examination caused the child to wake up and show resentment, whereas the right eyelid could be raised and the eye examined without any notice being taken of the procedure by the patient.—*Australas. Med. Gaz.—Canad. Pract.*

Treatment of Acute Orchitis.—M. Thiersy has treated for a long time acute orchitis by pulverizations of a solution of phenic acid on the inflamed organ. He considers it superior to emollient applications, and not only is it free from all danger, but it materially abridges the duration of the treatment.

The apparatus is a steam spray to be placed on a chair close to the patient. The solution should not exceed one in fifty, or two per cent, and the duration should not last more than one quarter of an hour twice a day, otherwise the skin would exfoliate. In three or four days all pain has subsided and the patient can leave his bed provided that he wears a suspensory bandage.—*St. L. Med. and Surg. Jour.*

The Palmo-Plantar Sign of Typhoid Fever.—Dr. Filipovitch, of Odessa, thinks he has discovered a diagnostic sign of typhoid fever that may prove serviceable in cases where at first the usual pathognomic symptoms are wanting. It is a peculiar callous look and an orange-yellow or saffron-yellow hue of all the prominent parts of the palms of the hands and the soles of the feet—parts which, as is well-known, are more or less rosy in health and become bluish in cases of cyanosis. The phenomenon is explained by the enfeebled action of the heart, a diminished amount of blood in the capillaries, and the dryness of the skin. He has observed it in every case seen by him during the last two great epidemics of typhoid fever in Odessa, and his observation is confirmed by another Russian physician, Skibnevsky. The sign disappears as soon as the convalescence begins.

Dr. Filipovitch's article appeared in the *Revue Médicale*, for August 20th, and an abstract of it is given in *Lyon Médicale*, for September 10th.—*Chor. Med. Jour.*

New Diagnostic Sign of Typhoid Fever.—Dr. Simon Baruch, *New York Medical Journal*, points out what he considers a new diagnostic sign of typhoid fever. He describes it as follows:

"So soon as the patient shows a rectal temperature above 102.5° in the morning and 103° in the evening for three successive days, especially if accompanied by headache, dullness, or apathy, he is placed into a full bath at 90°, which is reduced to 80°, with constant friction over the body. In three hours, the temperature still being above 102.5°, he receives another bath five degrees cooler. This is repeated until the temperature of the bath is 75°. If one or more of these baths fail to reduce the rectal temperature two degrees in half an hour, the diagnosis of typhoid fever is almost certain and the bath treatment is continued.

"The point emphasized is that the resistance of the rectal temperature to a bath of 75° for fifteen minutes with friction is an almost certain test of typhoid fever.

"If the rectal temperature before and after a bath of 80° to 75° is not reduced at least one degree in half an hour, the diagnosis of typhoid may be safely made, if other symptoms point ever so slightly in this direction. Hence the diagnosis of this disease should no longer be obscure even in the first days of its course."

Ætiology of Pemphigus.—Dr. Strelitz, assistant at the Polyclinic of Dr. A. Baginsky, Berlin, reports cultivating micrococci from the contents of the pustules or "blebs" of pemphigus neonatorum; that the characteristics of the micrococci were such as to identify them with *staphylococcus pyogenes aureus* and *albus*—results identical with those obtained by Almquist, who was able to experimentally reproduce pemphigus through inoculation upon his own arm. Strelitz chose one case occurring in a small endemic of five, repeated his cultivation experiments, and perfected them by inoculations on himself and on a student; the pustules continued to yield the yellow and at times also the white coccus, and with the former an eruption occurred corresponding to the pemphigus of the child.—*Med. Age.*

The Identity of the Streptococcus Pyogenes and the Streptococcus of Erysipelas.—The morphologic resemblance between the pyogenic streptococci and the streptococci of erysipelas early suggested the possibility of their identity, but it was difficult to furnish the proof to substantiate such a

belief. A case recently reported by Knorr (*Berl. klin Woch.*), of Berlin, would seem to furnish the necessary demonstration. The case was one in which in the sequence of an injury to the foot an abscess developed upon the thigh, and in the contents of which pyogenic streptococci were found. At a later date an area of erysipelas developed in the sacral region at the site of a small bedsore. The case terminated fatally, and after death examination of a bit of skin removed with suitable precautions from the erysipelatous area, disclosed the presence of streptococci that both in appearance and in behavior in cultures and upon inoculation were identical with those obtained from the abscess, while similar organisms could not be found in the healthy skin.—*Med. News.*

Surgery.

LAPARO-HYSTEROTOMY.—In an exhaustive article on the indications and technique of this operation, Professor Senn presents the following conclusions:

Conclusions.—1. Laparo-hysterotomy is justifiable when delivery through the normal passages is impossible without mutilation of the living child.

2. It is absolutely indicated when the conjugata vera is less than two and a half inches, when obstruction is due to fixed pelvic tumors and advanced malignant disease of the cervix.

3. Mutilating operations on a living child for the purpose of effecting delivery are no longer legitimate obstetric procedures, as laparo-hysterotomy and symphysiotomy are life-saving operations for both mother and child.

4. Hysterectomy after laparo-hysterotomy is only justifiable if the uterus itself is the seat of a life-threatening removable disease.

5. Elastic constriction as a hæmostatic measure should not be resorted to in laparo-hysterotomy before the delivery of the child.

6. The uterine incision should be enlarged to the requisite extent by tearing for the purpose of diminishing hemorrhage.

7. The visceral wound should be closed by four rows of sutures applied in such a manner as to absolutely arrest the hemorrhage, and completely separate the uterine from the peritoneal cavity.

8. Laparo-hysterotomy is only indicated in the operative treatment of single, large myo fibroma of the uterus in young women when the tumor is located within or near the uterine cavity.

9. In such cases, the uterine incision should be closed in the same manner as in operations on the pregnant uterus, and the bed of the tumor should be packed with iodoform gauze, which is brought through the cervix into the vagina, thus serving the double purpose as a hæmostatic tampon and capillary drain.—*American Journal of the Medical Sciences.*—*Int. Jour. of Surgery.*

THE FATE OF THE DRAINAGE TUBE AND THE IRRIGATOR.—The above title has suggested to the writer the remarkable changes recently observed by him in some of the operating theaters of world-wide reputation.

Then, where, O! where, we ask, is the ponderous irrigating jars, the yards of rubber tubing; and, where is our operator, in his massive wooden clogs or rubber boots, as he waded through pools of fluids, which, after they drenched the patient, flowed in torrents over his rubber-enveloped body?

And where is the drainage tube; that canalated conduit, without which, it was taught, a clean, dry wound would be impossible? The unfortunate wounded or mutilated had his body or limb so transfixed with this that they seemed like so many spines or spurs passing out of the openings made for them in the tissues.

Alas! in human fallibility the day of the tube too is numbered. Yes! all this artillery of monster jars, hydraulic apparatus, steaming boilers and multiple formidable drainers has no place in the hands of a rational operator, unless he attaches a leading importance to stage fixtures and theatrical effects.

In Sir Joseph Liester's operating room one is quite confounded at the simplicity of operative manual.

We look in vain for the white-frocked operator. The manager, with his coat on, turns up the sleeves, washes his hands, and slips on a pair of sleevelets, which are tied at the shoulders and wrists. A nurse with a quart hand-bowl in hand, supplies all the necessary douching material. The drainage tube is never seen, except in foul suppurating wounds. Yes, we have drained too much, we have irrigated too much. They are invaluable agents in rare, unusual cases. In clean, healthy wounds they are not only useless, but harmful, and might as well be thrown out altogether as used to the absurd and needless extent which has heretofore characterized their employment.—*Editorial, Times and Register.*

THE VALUE OF THE HANDS AND OF THE FINGERS.—Surgeons have often to estimate the chances of saving injured hands, and the comparative values of hands and fingers. According to a scale of value furnished by the Miners' Unions and Miners' Accident Insurance Companies of Germany, the loss of both hands is valued at 100 per cent, or the whole ability to earn a living. Losing the right hand depreciates the value of an individual as a worker seventy or eighty per cent, while the loss of the left hand represents from sixty to seventy per cent of the earnings of both hands. The thumb is reckoned to be worth from twenty to thirty per cent of the earnings. The first finger of the right hand is valued at from fourteen to eighteen per cent, that of the left hand at from eight to 13.5 per cent. The middle finger is worth from ten to sixteen per cent. The third finger stands least of all in value; although like other useless members of the community, it is surrounded by riches, its value is only from seven to nine per cent. The little finger is worth from nine to twelve per cent. The difference in the percentages is occasioned by the difference in the trade, the first finger being, for instance, more valuable to a writer than to a digger. —*Med. News.*

REDUCTION OF DISLOCATIONS BY OPERATIVE MEANS.—Prof. Helferich regards reduction of dislocations by operative measures as indicated in recent cases which have proved irreducible under the customary treatment. While the opening into joints was formerly always considered as a dangerous proceeding, it is, in his opinion, perfectly harmless under the aid of antisepsis. It has been the custom in cases of irreducible dislocations to cut down on the joint and then perform a typical resection. At the present

time, however, no surgeon would any longer undertake a resection on principle, if he were able to effect reduction by manipulation, by division of tense or interposed fascia, without excising the ends of the bones. An incision into the joint under antiseptic precautions is far more harmless than a complicated luxation in which there is always danger of infection. The operation presents no difficulties, and if no complications exist, a restoration of function may be hoped for. The author reports three cases which were treated by this method, in two the dislocation involved the elbow joint, in one the hip joint. Reduction was impossible in the three cases by ordinary measures, while it was readily effected after operation. After the lapse of a few weeks complete mobility had returned. These cases prove that the impossibility to reduce a simple luxation no longer justify any one to give up the attempt at reduction and to wait for the development of a nearthrosis. Every luxation should be reduced, either in the customary way or by operation. The earlier reduction is accomplished, the greater the restoration of the functions of the joint.—*Deutsche Medicin Wochenschr.* —*Int. Jour. of Surgery.*

THE ROLE OF THE POSTERIOR URETHRA IN CHRONIC URETHRITIS.—Dr. Bransford Lewis, of St Louis, in a paper read before the American Association of Genito-Urinary Surgeons, announces his conclusions as follows:

"1. The causes usually given for the prolongation of cases of clap (presence or absence of gonococci, stricture of large caliber, the use of particular drugs in treatment, etc.), do not satisfactorily explain them, nor do they furnish reliable means for prognosticating the outcome of a case.

"2. A single widely prevalent cause for such prolongation of gonorrhœa has as yet not proved its right to recognition as such.

"3. Posterior urethritis, by reason of its anatomical seclusion and inaccessibility to ordinarily prescribed treatment, if frequent, offers the best explanation for such prolongation or repeated recurrence.

"4. Scrutinizing clinical investigation shows posterior urethritis to be present in the great majority of cases of prolonged or severe gonorrhœa.

"5. Direct, topical treatment to the posterior urethra is therefore necessary in the great majority of cases.

"6. The causes usually given for producing posterior urethritis are not commonly found to be real factors in the clinic.

"7. The mode of onset usually described does not coincide with that discerned in clinical observations.

"8. These latter two observations confirm the probability that the posterior urethral infection is accomplished through the lymphatics, and explain the frequency of such infection.

"9. Posterior urethritis is not a complication, but a natural phenomenon of gonorrhœa."—*Med. Bulletin.*

VARICOSE ULCERATIONS OF THE RECTUM AND ANUS.—In the *Revue de Chirurgie*, Quénn writes on this subject. No other mucous membrane is so frequently the seat of ulceration as that of the ano rectal region. Ulcers here may occur in the course of a general affection, as tuberculosis, dysentery, syphilis, Bright's disease. Perhaps more frequently they result from purely local causes, such as soft chancre, mechanical obstruction, or disintegration of a neoplasm. Besides these symptomatic, constitutional and venereal ulcers, a variety is met with that merits the title "simple ulcers of the rectum."

Simple ulcer is most frequently limited to the region of the sphincter; at times, however, it may be situated higher in the rectal mucosa. The most common of the simple ulcers in the sphincteric region is the ordinary fissue-in-ano. Along with this may be classed the irritable and painful ulcer of Allingham, and the varicose ulcer. According to Allingham, irritable ulcer differs from the simple variety by being round in shape, and by the high situation of the former, which may even be within the internal sphincter. Chronic varicose ulcer was first described by Rokitansky. It is always found in connection with hemorrhoids. In this variety there is less thickening of the borders and less pain than in fissure.

A person suffering from hemorrhoids is more prone than others to fissure, which may develop into a true ulcer. In women, exploration of the rectum is facilitated by introducing one finger into the vagina and pressing downward. As a further assistance the patient may be asked to bear down.

In simple ulcer above the sphincter, the lesion is round, the edges are thickened, the base unequal and red, and very vascular. The varicose ulcers are divided into the irritable and the nonirritable. The irritable variety includes the round ulcer, the painful and irritable ulcer of Allingham, and the more common fissure-like ulcer. The symptoms closely simulate those of fissure. The nonirritable variety includes the superficial ulceration of the mucosa, the small round ulcers, supra- or infra-sphincteric, and the larger ulcer of the margin of the anus, of Péan and Malassez. These are most common in middle and later life. The primary round ulcer is more particularly observed in the aged. The nonirritable varicose ulcer presents three principal symptoms: sensory disturbances, the discharge of mucus more or less purulent, and hemorrhage. The latter is the most important of these, and is at times profuse. The diagnosis depends upon detecting the presence of the ulcer, and determining its exact nature. Digital examination will detect a painful area. It is necessary to employ the speculum for ocular examination.

Syphilitic lesions of this region may belong to the primary, secondary, or tertiary stages. Hard chancre presents its usual characteristics. The lesions of the secondary period are mucous patches, and of the tertiary period, ulcers; the latter is rarely observed. Tubercular ulcers have been observed as primary lesions and as secondary to pulmonary disease. According to Ball, they present large lesions in the rectal or ano-rectal mucous membrane; they are irregularly rounded and elongated in the vertical diameter; the borders are irregular and raw; the mucous membrane in the neighborhood is infiltrated and thickened.

The treatment differs with the seat and variety of the lesion. For fissure, the usual treatment suffices. Round ulcers of the margin of the anus require topical applications; they may be cauterized and dressed antiseptically or excised. Superficial erosions may be excised or cauterized. Suprasphincteric ulcers require the galvano-cautery. Anæsthesia is necessary, and the use of the Sims speculum to give access to the lesion. Boric acid lotions and iodoform tampons may be used in the after treatment, and antisep-

tics, such as naphthol, administered internally—*Amer. Jour. of Med. Sciences.*

TREATMENT OF SYPHILIS.—I have surely not the intention, in this correspondence, to speak to you of the last work of Professor Fournier upon the treatment of syphilis. It is a book to have, and one which one can scarcely analyze. Its appearance has freshened an old quarrel. It is well known that Professor Fournier believes that we must treat methodically and preventively every primary and secondary syphilis. Usually he prescribes to a patient who comes to see him at the beginning of his syphilis, a course of proto-iodide of mercury, in daily doses of six centigrams, to be taken for at least two months. Then this treatment is suspended for a month to six weeks, after which, no matter what has happened, whether the patient has or has not shown new developments, he has him take up the treatment by the proto-iodide again for about six weeks. Then there is a new period of repose for two or three months, renewed administration of the proto-iodide, new repose, and thus on until the third year of the disease. At this time he gives iodide of potassium in daily mean doses of three grammes, during periods of from one month to six weeks, separated by intervals of rest, growing gradually longer as the time from the commencement of the disease increases. His treatment is thus a systematic one, very prolonged and intermittent. On the other hand, there are syphilographers in France, and Dr. Diday, of Lyons, is their venerated chief and dean, who maintain that we must never treat a syphilitic excepting when visible manifestations are present; that we must cease the impregnation with mercury as soon as there are no longer manifestations of the disease, for, according to their view, mercury has no antisyphilitic action in a preventive sense. This is the method called *opportuniste.*

You can understand how this debate is vigorously contested, and how important a thing it is that the question should once and for all be definitely settled. The appearance of Professor Fournier's book immediately called out the publication of an answer, in which Dr. Diday refutes the arguments of his adversary, and in which he shows, in the most spirited manner, how, with a little dexterity, one can take the opposite side of any question and make statistics serve the purpose of proving any opinion. After reading most of the documents which have appeared on this point, one arrives at the conclusion, truly deplorable, that one cannot form a firm conviction, and that the two opinions are defensible, although, according to our views, that professed by Fournier seems to repose upon a more scientific base. However, in reasoning from another point of view, it seems to us that, when in doubt, one should not abstain from treatment, since the doses of medicine that are given at the present day are, in the immense majority of cases, in no wise injurious, and they should be continued with; for if they are omitted, severe accidents may occur, and there will be no excuse.—*L. Brocq, in Jour. Cutaneous Dis.*

SUPRAPUBIC LITHOTOMY.—Lawson Tait describes the technique of this operation: "I make use of no precautionary measures or preparatory steps. I neither pack the rectum nor distend the bladder. I stand on the left of my patient and cut upward two inches and a half, starting immediately over the ridge of a pubic arch, exposing the tendon at one sweep. I then cut the tendon traversely over about one inch close to the bone, and cut it centrally for an inch and a half. I then pass my left forefinger between the bladder and the pubic arch, and follow it with a pair of forceps. I gently rend the tissue till I can feel the bladder wall. This can easily be determined by its peculiar feeling, and by the fact that once the forceps grip it they hold, and they do not hold merely cellular tissues. Having fixed one pair, I then fix another close to them. My assistant takes them and gently pulls them apart, as in abdominal section; a notch of the knife follows, and a rush of water declares the road into the bladder for the forefinger to be open. The rest is all finger work, and consists as in abdominal sections of a gentle, but firm extension of the opening into the bladder, till the lithotomy forceps can follow it. All my cases have recovered without complication, and though up to the present I have used a glass drainage tube, I am of the opinion that this will prove an unnecessary precaution, and that it will be safe to close the bladder by deep sutures."—*Med. and Surg. Rep.*

INJUDICIOUS NASAL OPERATIONS.—In opening the discussion on this subject at the late Pan-American Congress, Dr. Hobbs said:

If our friends, the gynæcologists, have their nymphomaniacs, I think we too may have our *rhinomaniacs.* We have a class (and it is a rapidly increasing class) of patients who consult us with the avowed purpose, to use their own language, "of having their noses burned out."

In some respects these two classes are analogous, in that the neurotic factor is often present also in our *rhinomaniacs,* as it is always present in nymphomaniacs.

My point is that we may, without much exaggeration, lay the blame of the injudicious, or at least the unnecessary operation, when we make it under such circumstances, upon the patient himself, unless we place it upon a higher plane, and refuse in all such cases even the pretense of an operation, as a placebo, or for its moral effect, when its necessity is not indicated. While judicious and properly executed rhinal operations have done, and are doing, an immense amount of good, for this very reason the temptation is increased in many instances to do operations that were better not to have been done, particularly by the younger men just making their entree into this special line of work. They are loth to allow an opportunity to pass to saw a septum, to drill an exostosis, or to cauterize a turbinate. The mere suggestion of a septum spur, or a bony protuberance, or an enlarged turbinate is too often deemed a sufficient reason for a surgical procedure even though no subjective or other objective symptoms may exist. When we are reminded of the large area of nasal mucous membrane, its functions should at once be suggested. The nasal space was intended to breathe through and only secondarily to serve as an olfactory organ.

As this great expansion of mucous surface, twice that of the so-called throat, is intended to perform the important functions of moistening and warming the inspired air, the necessity of its preservation should never be lost sight of. Hence any nasal operation made without reference to the mucous membrane preservation is not only injudicious but harmful, provided the nature of the case does not necessitate

its destruction. And again, where no operation can be made without resulting in a large cicatrix the question may arise, "would it not be better left undone?"

In cases where chromic acid or any other escharotic would seem to be more appropriate on account of the timidity of the patient, or for any other reason, the toxic sequence should always be considered, otherwise the operation may prove to have been an injudicious one.

Septum deflections, spurs and exostoses should always be carefully measured before any operative procedure is resorted to, else a perforation may result that would be worse than the primary condition.

The drill is, in my opinion, almost always an injudicious device, for the reason that it necessarily destroys so much mucous membrane and leaves a rough cicatricial surface, although I find myself resorting to it in some cases of prominent exostoses.

To attempt to generalize upon the many injudicious external operations that are resorted to most frequently in malignant growths, and occasionally in large benign tumors, would require too much of your time, since each case of so serious a nature is a law unto itself and should always be so treated.—*Atlanta Med. and Surg. Journal.*

TREATMENT INDICATED AFTER TRACHELORRHAPHY.—Dr. William H. Robb said that in the majority of cases trachelorrhaphy restored the parts to their normal condition and the patient to health. In a few instances, however, this result did not follow, and in order to trace the reason therefor, Dr. Robb described briefly the anatomy of the pelvic organs, especially of the uterus, the changes which take place during pregnancy and subsequent involution. Laceration of the cervix, when of sufficient severity, left the womb in a state of subinvolution, and was followed by various pathological changes in the cervix and neighboring parts. Treatment after trachelorrhaphy was general and local. Of many drugs, he wished to mention two from which he had obtained particularly good results when administered internally—they were mercury and iodide of potassium. The local treatment required the patient to be put to bed, position, hot douches, glycerine tampon, tincture of iodine, abstraction of blood from the cervix, etc.

Three months of this treatment often started an improvement which terminated in recovery. The condition most frequently found in his practice had been endometritis, often complicated with fungous degeneration. Scraping of the entire endometrium and drainage with gauze were indicated. In case of inflammatory pelvic deposit galvanism had spared the necessity for abdominal section. If there were imperfect union of the cervix a second operation would be called for. When all treatment failed, the woman could be promised removal of the appendages after the menopause.

Dr. A. Palmer Dudley, of New York, thought that if the after treatment described by Dr. Robb were carried out before trachelorraphy, there would be no failures from the operation itself. Then, in repairing the cervix, he divided the uterine artery on both sides and ligated it with the sutures, so that the blood supply to the hyperplastic organ was cut off during about forty days. By that time great reduction in size had ensued. In the preliminary treatment of the diseased and enlarged uterus he touched the parts with pure carbolic acid. Free drainage was essential. He advised that the cervix be repaired immediately after labor where possible. He had done this in a few cases, employing reflected light.—*Med. Record.*

A NEW METHOD OF REDUCING DISLOCATION OF THE LOWER JAW.—Dr. Roth describes his method of reducing maxillary dislocation as follows: 1. The patient seated in an ordinary chair, the operator stands before him with one foot placed slightly to the right side and the other just in front of the patient and in the middle line. 2. He then flexes himself at the hips and causes the patient to lean forward and to place his forehead at the middle of the operator's sternum—but this position varies with the size of the patient's head. 3. The operator now flexes his head so that his chin grips the patient's head about the upper part of the occipital bone, thus acquiring a firm hold with the head well under control between his chin and chest. 4. The thumbs, protected in the usual manner, are placed in the patient's mouth and the fingers of both hands grasp his lower jaw. The author considers that his method has the following advantages: *a.* The operator has the head under perfect control and perfectly fixed; *b*, the line of force exerted by the operator's hands acts in the same line as the resisting force exerted by the operator's chin; *c*, the operator's elbows, being well flexed, he can exert a greater power by the force acting through the thumbs close to the shoulders; the terminal phalanges will be found to have greater muscular power; *d*, the patient's head is in a better position for reducing the dislocation; and *e*, the operator needs no assistant, and does not inconvenience his patient by excessive pushing and pulling the head about during the reduction.—*The Lancet.—Nash. Jour. Med. and Surg.*

POTT'S FRACTURE.—Prof. C. S. Briggs made the following remarks (*Nash. Jour. Med. and Surg.*) on presenting a case of this injury to his class:

We are glad to be able to present to you a case of fracture in this patient, John A., aged forty-two, who in a drunken jollification of a political victory last night, stepped from a slight elevation to the floor in such a way as to forcibly twist his foot outward. As a result the internal lateral ligament of the ankle joint was ruptured, the tibia was dislocated from the astragalus and the fibula was fractured in its lower fourth. This constitutes a typical example of Pott's fracture. The deformity is characteristic. The foot is extremely everted, occasionally to such an extent that the outer border of the foot is almost in contact with the leg. The usual signs of fracture, crepitus, preternatural mobility, and deformity, are readily made out. The dislocation of the tibia is a necessary feature. Very frequently the internal malleolus is thrust through the soft parts, which necessarily adds greatly to the gravity of the case. As an immediate dressing for this fracture, Dupuytren's splint is to be especially commended, inasmuch as it corrects the deformity more certainly than any other. It consists simply of a firm splint of wood to reach from above the knee to three inches beyond the bottom of the foot. A wedge-shaped pad, made of cloth stuffed with cotton, long enough to extend from the knee to just above the internal malleolus, is applied to the inner side of the leg from the knee so as to have the thickest portion rest just above the ankle. The splint is

placed upon the pad and held in place by a bandage, the first turns of which hold the foot in a position the opposite of that in which it has been displaced, that is, in extreme inversion. This dressing was adjusted last night, and being removed you observe the deformity has been corrected. As a permanent dressing, we will now put the foot and limb in a plaster of paris splint, which you will see differs very materially from the plaster of paris bandage applied to the patient just removed.

The limb is first bandaged from the foot to the knee. Usually a woolen stocking is best to use to protect the leg and foot. Strips of crinoline, of a width nearly equal to half of the circumference of the calf of the leg and of about four yards in length, are folded in lengths equal to the distance from the knee to the bottom of the foot, and sewed together in the middle. We thus have two sets of crinoline strips, each containing about eight thicknesses, held together by the seam, which are to be cut in shapes to fit each side of the leg. Two or more crinoline bandages are rolled, and placed in water. The splints are soaked in water, wrung out and hung up on a chair. A mixture of plaster and warm water is made of about the consistence of a poultice. In this the splints are placed, and kneaded until the meshes of the cloth are thoroughly saturated with plaster, when they are applied to the sides of the leg, care being taken that their edges do not meet either in front or behind. These splints are held in place by the crinoline bandages applied from the foot to the knee. The dressing is allowed to dry, and the plaster having set, the limb is encased in a fixed dressing that posesses all the advantages of the plaster of Paris bandage without any of its dangers. To-morrow the dressing will be opened by cutting in the space between the anterior edges of the splints, when it can be easily removed, the turns of the bandage behind serving as a hinge to hold the splints together, and to allow them to open upon each other. This method has the great advantage of enabling the surgeon to inspect the seat of fracture as often as may be necessary—an essential in this case in particular, as the tissues over the internal malleolus show considerable contusion, which may lead to sloughing.

The Early Management of Club-foot.—Dr. De Forest Willard, in a clinical lecture of this subject offers the following conclusions:

1. The first month of life is the period of greatest growth, and to neglect treatment of club-foot during this time is to permit the bony and soft tissues to become permanently misshapen.
2. Rectification should be commenced from birth by various simple measures.
3. Correction can be accomplished by a variety of dressings.
4. Manipulation is exceedingly important for the production of a flexible foot.
5. Apparatus should be applied as soon as the foot and leg are in position for its application.
6. Rectification and manipulation should be continued up to the age when the infant is ready to walk, at which time, if the foot cannot be placed upon the sole firmly operative measures should be instituted.—*Therap. Gazette.*

Hernia of the Vermiform Appendix.—Dr. A. Brieger, Breslau, the author, considers only the cases which contain only the vermiform appendix in the hernial sac. The origin of such hernia can be classed under two heads, the same as all other hernia; namely congenital and acquired. First form is usually found to be caused by the adhesion of the vermiform appendix with the testicle during fœtal life. A second cause, of equal importance, which may form during early fœtal life, is the patulous condition of the tunica vaginalis, which may act as a channel through which may pass an appendix of abnormal length. Other predisposing causes are, a long mesentery to the appendix and displacement downward of the cæcum.

The author reports six cases of irreducible hernia of the vermiform appendix, the last having occurred at the surgical clinic of Breslau. He further describes eighteen cases of incarcerated hernia of the vermiform appendix, the last one a case also belonging to the above named clinic. He adds two cases in which the hernial sac contained the appendix and a portion of the omentum.

The author concludes his article as a result of his observations:

1. That herniæ of the veriform appendix are of more frequent occurrence than is generally known.
2. It is impossible to make an accurate diagnosis of such hernia. When symptoms of incarceration occur, hernia may be considered in connection with the right inguinal or femoral hernia.
3. There is always an important point to remember, which is that the vermiform appendix frequently undergoes pathological changes which produce often marked complications.
4. These cases, even if irreducible, require early operations owing to the fact of complications arising from the appendix.
5. The operation, with few exceptions, consists in resection with acurate closure of the lumen, after the method of Mikulicz. Reduction can only be practiced in such cases where the appendix is normal.—*Arch. f. Klin. Chir.—Med. and Surg. Reporter.*

Horsehair in Minor Surgery.—Dr. Thompson offers the following summary of the advantages of horsehair in surgery:

1. Easily obtained and inexpensive.
2. Soft, pliable, elastic and holds a knot well.
3. Aseptic, nonabsorbent and nonirritating.
4. Can be used with a very small needle, and makes no shoulder at the eye.
5. More easily removed than any other suture, without pain or injury to the tissues.
6. Can be used for drainage.—*Med. and Surg. Reporter.*

Curved Skin Incisions.—Mr. Peyton T. B. Beale advocates the use of curved incisions wherever possible. The following advantages are claimed:

1. It heals more rapidly, and for these reasons: There is really only one edge of the wound, that belonging to the flap, that is movable, the other edge being still adherent to the subjacent tissue; moreover, the flap having been stitched to the neighboring skin or held well away from the seat of operation, both edges of the wound are quite uninjured by the time the sutures are inserted.
2. The resulting scar is smaller, though this is only of importance in certain parts, for the skin may be incised obliquely in making a curved incision, so that

the epidermis on the edge of the flap is slightly in advance of the true skin.

3. It fully exposes the part to be operated upon, assuming that the base of the flap is twice or three times its length, and gives the operator plenty of room in which to work.

4. Suturing the edges is easier than in the case of a straight incision, especially if the skin be pricked in one or two situations exactly opposite to one another before the incision is made, and often the curved wound is adapted to the shape of the part better than a straight one.

5. The resulting cicatrix is not over the seat of operation.

6. Drainage is often most perfect by inserting a tube through an incision in the base or some part of the flap, thus giving no hindrance to the primary union of the incision and preventing any possible discharge from infecting the edges.

7. Incision through inflamed or diseased skin may be avoided and yet the disease be easily reached.

8. There need be no tension on the edges of the wound, as a flap of skin is, so to speak, loose, and if there is fear of tension a thick silk suture may be passed through the base or some part of the flap and out again, and then through the skin on the other side of the incision and there fixed, thus avoiding a long suture beneath either edge of the wound.—*Canad. Pract.*

TRAUMATIC MENINGEAL HÆMORRHAGE; SUCCESSFUL OPERATION.—So seldom do cases of head injury present themselves with definite symptoms of any one lesion, especially such as may be successfully treated by operative interference, that the case recorded by Mr. Archie T. Collum of extra-meningeal or subcranial hæmorrhage cannot but be highly instructive in many ways. A man of thirty-seven was admitted to Charing Cross Hospital for a compound depressed fracture of the skull. He became insensible at the time of the accident, but was found to have recovered consciousness on his arrival at the hospital. The pulse was ninety, the respiration normal; and there was no collapse. There was hæmorrhage from a clean-cut wound which penetrated all the layers of the scalp; the center of this was vertically over the right pinna, four inches above Reid's base line. At the bottom of the wound a fracture was exposed, and an elongated piece of bone was found driven inward by the injury. The patient felt quite well an hour after his admission to the hospital. He vomited however a few hours later; and his general condition then was observed to change. He became drowsy and stupid, and only answered questions when shouted at. His articulation also became quite indistinct; and he assumed an irritable condition, resenting disturbance and keeping his eyelids closed. At this time there was no paralysis. The drowsiness then gradually deepened, and he became semi-conscious, with stertorous breathing, and a pulse of sixty-four, irregular and not bounding. Paralysis was now noted on the left side of the body, partial in the leg but complete in the arm and face, including the orbicularis palpebrarum and frontalis; analgesia was also present. All movements on the right side of the body was strong, with unimpaired sensation. Both knee-jerks were present; and therewas a slight tendency to ankle clonus on each side. The right pupil was smaller than the left; both sluggishly reacted to light; and there was no proptosis or conjunctival congestion The patient had therefore a hemiplegia on the side opposite to the head injury, and a contracted pupil on the same side, with a pulse that had fallen from 90 to 72 and finally to 62, apparently due to the increase of the intracranial pressure. Mr. Stanley Boyd, on examining the patient, decided on immediate operation, and successfully removed the depressed fragment, which was found to consist of both tables of the skull beveled all round at the expense of the outer. A dark nonpulsating clot of blood presented on the removal of the fragment. It separated the dura mater widely from the bone. The clot was removed, and two bleeding points were found. The upper one of these consisted of an incomplete tear of the dura mater, from which arterial blood was oozing; the other was a small pumping vessel. No actual perforation of the dura mater was detected. The bleeding was successfully stayed, and the wound closed except at the anterior angle, where a strip of iodoform gauze was employed as a drain. The patient was allowed to recover partially from the anæsthetic toward the end of the operation, and it was at once noticed that he had regained much power in the paralyzed leg and that the pupils were of equal size. He was again sensible four and a half hours after the operation, and was able to lift his left arm and leg. The patient made an excellent recovery, never had a bad symptom, and was discharged on the nineteenth day following his injury.

Mr. Collum, in commenting on this case, points out that there was a period of momentary concussion, then a conscious interval of five hours, which was followed by a period of rapidly increasing compression commencing with drowsiness or stupor and gradually deepening into semi-unconsciousness. A fatal result was apparently prevented by surgical interference. The presence of paralysis on the one side of the body and of ocular symptoms on the other side sufficiently indicated the seat of the lesion in the absence of a scalp wound; while the rapid supervention of compression pointed to hæmorrhage as being its cause; the short concussion period and the absence of previous "cortical spasms" suggested that the brain was uninjured, and at the same time localized the blood to the subcranial situation.—*The Lancet.*

THE USE OF SALINES IN APPENDICITIS.—Dr. M. H. Richardson, surgeon to the Massachusetts general hospital, calls attention to the harmfulness of cathartics, especially saline, in appendicitis, in the *Boston Medical and Surgical Journal.* He says:

"The theoretical action of cathartics in peritonitis as given by various men, consists in an absorption and removal by intestinal drainage of the toxic products of certain microörganisms which, multiplying in or near the peritoneal cavity, endanger life. I do not object to carrying out this theory after the appendix has been securely tied, or after it is clear that there is no danger of rapid extravasation; but in the first forty-eight hours of appendicitis I look upon the administration of salines as extremely dangerous, and as a not infrequent cause of general peritonitis and death. The reasons for this lie in the pathological conditions that exist in a very considerable percentage of cases. If in a given case there is a perforation in an appendix of large lumen, salines, by liquefying the feces and increasing peristalsis *will cause an immediate and almost invariably fatal extravasa-*

tion. In such a pathological condition, which is not infrequent, the use of cathartics before removal and ligation of the appendix must be and is attended by most fatal consequences.

"There is the same objection to the use of salines in gunshot wounds of the intestines, in perforations of typhoid fever, or in perforating ulcers of the intestinal tract generally.

"If the appendix has been tied off, or if the peritoneal cavity has been walled off, with gauze, or if there is a firmly localized peritonitis, I do not object to cathartics, and I use the salines freely. I must say, however, that in a completely established general peritonitis, from whatever cause, with distention, vomiting and obstipation, in my experience, salines accomplish absolutely nothing.

"To produce 'intestinal drainage,' after abdominal operations, I think salines most excellent; and they have their use in the very beginning of a peritonitis in which there is no question of extravasation. I believe the future use of salines will be confined to these conditions."

The attention thus called to the indiscriminate use of cathartics in inflammatory conditions with perforations, or that are likely to result in perforations, is timely—already too many lives have been sacrificed by a blind conventional custom to give salines in every sort of peritoneal inflammation without question as to its locality, extent or possibilities.—*Times and Register.*

Therapeutics.

Carbonate of Guaiacol in the Treatment of Typhoid Fever.—The *Med. Week* for June 30th, contains an abstract of Dr. F. Holscher's experience in the treatment of typhoid fever by the administration of carbonite of guaiacol in doses of fifteen grains night and morning. With this treatment the tougue became moist, the appetite returned, and the stools, that smelled strongly of guaiacol, gradually assumed a firmer consistence. In some instances the administration of the drug was even followed by constipation, but this usually disappeared spontaneously, seldom calling for the administration of enemata. It exerted a favorable influence on the bronchitis that so frequently complicates typhoid fever, relieved dyspnœa, and facilitated expectoration. It is not an antipyretic, but an intestinal antiseptic, and has no effect on the temperature when administered alone; but with acetanilide the effect produced is more marked and lasting than that obtainable with any other antipyretic. By its antiseptic action on the intestinal contents it prevents the formation of toxic products in the intestine, and the accidents caused by the absorption of these toxines into the circulation are prevented. Hence the patients treated by this method seldom show any ataxic of the bowel; the other reported, at the end of eleven weeks, that the function was entirely normal.

In the first case the torsion was carried to 180°; in the second it was carried to 270°. The bowels were moved on the fifth and sixth days respectively. Drainage was employed in both cases, and the wounds closed.

The mechanism of this narrowing of the lumen is accomplished simply by means of the torsion; and the extent to which it is carried must be governed by the finger introduced into the bowel. The operation is applicable not only to amputation recti, but to every artificial anus; and also in cases in which an artificial anus has been made, and in which incontinence exists, the gut may be freed, twisted and again sutured to the surface opening.—*Annals.*

The Use of Cocaine.—1. Amount of cocaine used must be in proportion to extent of surface it is desired to anæsthetize. In no case should the quantity exceed one grain and three-quarters.

2. Cocaine should never be used in cases of heart disease, pulmonary disease, or in persons of highly nervous temperament.

3. In injecting cocaine, the intradermic method is preferable to hypodermic. By injecting into, not under mucous membrane or skin, the risk of entering a blood vessel is avoided.

4. During injection the patient should always be in a recumbent position; in operations upon the nose and throat, the head should not be raised until anæsthesia is complete.

5. It is of great importance that cocaine should be pure, since its combinations with certain other alkalies result in poisonous compounds.—*Brooklyn Med. Jour.*

The Administration of Anæsthetics.—The following deductions (*Lancet*, No. 3642, p. 1498) have been arrived at by the Commission appointed by the *Lancet* to investigate from a clinical standpoint the subject of the administration of chloroform and other anæsthetics: The death rate under anæsthetics has heretofore been unduly high, and may be lowered by improved methods and greater care. Ether is the safest anæsthetic in temperate climes for general surgery, when properly given from an inhaler permitting graduation of the strength of the vapor. Nitrous oxide gas should be employed for minor surgery. Chloroform is a comparatively safe body when given by a carefully trained person, but is not in any case wholly devoid of risk. No age or nation is free from danger under anæsthetics. The perils of anæsthesia, however slight, demand that the undivided attention of a duly qualified and trained medical man should be given to the administration of the anæsthetic.—*Med. and Surg. Rep.*

The Action of Pilocarpine on Bodily Temperature.—In a series of experiments conducted by Prof. Reichert on this drug the doctor states that the results of his observations justify the following conclusions:

1. Pilocarpine first increases and then decreases bodily temperature.

2. Heat production and heat dissipation are first increased and then diminished. Heat production is the process primarily affected, the alterations in heat dissipation following and being dependent upon the effects upon heat production, excepting after very large doses, when heat dissipation may be depressed even more than heat production during the stage of lessened heat production.

3. The alterations in temperature are dependent essentially upon the actions on heat production, but may be affected by sweating, and after very large doses by alterations in heat dissipation.

The primary increase of temperature is due primarily to an increase of heat production, but after very large doses this increase may be exaggerated

and continued by a diminution of heat dissipation which is greater than the depression of heat production.

The decrease of bodily temperature is due to a diminution of heat production, but may, in part, be due to sweating.

4. The actions on the process of heat productions are so much more potent in their effects on temperature than those on the sweat glands, that it is doubtful if the latter ever plays an important part in the temperature alterations.

5. Bodily temperature may be increased during the stage of diminished heat production, owing to the greater depression of heat dissipation.

6. The amount of increase and decrease of temperature and the duration of each of these periods are essentially in direct relation to the dose.—*Univ. Med. Mag.*

Crude Pyroligneous Acid in the Treatment of Gonorrhœa in Women.—In the *Algemeinem Krankenhous* in Vienna the following outlined treatment is regularly employed in the gynæcological wards for the cure of gonorrhœa. The patient is placed in the dorsal position and a cylindrical speculum introduced. When the os is thoroughly exposed the external end of the speculum is elevated and about an ounce of crude pyroligneous acid poured in. This is allowed to come in contact with the parts surrounding the os, after which the speculum is slowly withdrawn to the vulva permitting the acid to come in contact with all parts of the vagina as it follows the speculum. The speculum is not entirely withdrawn, but is reintroduced and then gradually depressed and the acid allowed to flow out through the cylinder into a basin, care being taken not to stain the linen of the patient. This is done every second day and results, in a large majority of cases, in a cure after the third or fourth application.

In most cases the patient complains of a but slight sensation of warmth; if the inflammation is very acute the pain is more severe, though even then not extremely so.—*Pitts. Med. Review.*

Antiseptic Varnish.—Dr. Berlioz gives the composition of this varnish, which will be found useful on mucous membranes and where it is difficult to keep any other dressing on. He calls it *steresol.*

℞ Gum lac, purified and soluble in alcohol..270 grms.
Benzoin the same.....10 grms.
Balsam of tolu.....10 grms.
Carbolic acid, crystalized.....100 grms.
Oil of cinnamon.....6 grms.
Saccharin.....6 grms.

Then add alcohol to make a quart.

—*St. L. Med. and Surg. Journal.*

Therapeutic Uses of Olive Oil.—In 1848, in the treatment of a very severe case of hemorrhoids, I was using olive oil combined with chloride of sodium freely as an injection into the rectum, and giving tablespoonful doses of the pure olive oil from every one to four hours by the mouth to produce a free and mild cathartic action, which resulted in a discharge of over one hundred gall-stones. From that time to the present I have used no other treatment, and have had a very large practice in cases of gall-stone. Patients are brought from a distance in this State, also from the State of New York, to be treated for what they are told is a "disease of the liver." I will quote one case—a student of a medical college, in a city not in Pennsylvania. He was placed in the hospital, and under the care and directions of the professors of that college. They could not agree as to the case, two agreeing it was abscess of the liver, and to prove they were right introduced an exploring instrument, but found no abscess. The patient was very low and they thought he must die, so telegraphed to his friends in Western Pennsylvania to come and take him home. They went at once, finding him alive, brought him by the first train, on a bed in a drawing-room car, to his sister, residing in Ridgway, perfectly helpless. She, too, thought he could not live, but as I was her physician, asked me immediately after his arrival to come in and see him. I called, found him in bed, helpless and very weak, but after examination, I laughed, and the friends said they wished they could laugh, too. I replied, "You will soon." I commenced treating him with pure olive oil and other medicines for catarrh of the stomach, bowels, etc., and directed the nurse to carefully save all discharge from the bowels and let me see all sediments. In the course of two days, he passed more than two hundred gall-stones; passing them at every evacuation until at the end of three days they amounted to more than three hundred. He was soon well, and returned to his college and finished his course.—*Earley in Col. and Clin. Rec.*

Bee Virus for Acute Rheumatism.—In the Bulletin of the Entomological Division of the Department of Agriculture, Mr. John Wetherington, United States Consul at Malta, advocates the bee sting as an infallible remedy for acute rheumatism, on the ground that it is universally employed by the country people of that island. It is, in fact, said to have been a common practice for generations past to resort to this remedy in all severe cases, the results being most favorable.

If this statement is true and the same virtue dwells in the virus of the sting of the active bee of America, surely some of our brethren in the rural districts should be able to give the remedy a practical test.—*Med. Age.*

The Treatment of Warts.—Prof. Kaposi, of Vienna (*La Semaine Médicale*, No. 52, 1893), recommends, when the warts are solitary, removal by the knife, but when multiple, and especially on the face he employs the applications of thuya occidentalis or fuming nitric acid. Vegetations are best treated by dusting with resorcin or salicylic acid or a plaster of ten to twenty per cent. Resorcin, if applied for a long time, acts as a caustic, and may irritate the surrounding normal skin. These same topical applications are also excellent in keratosis palmaris and plantaris, even when they are not wartlike. In multiple warts of the face he employs the following:

℞ Flowers of Sulphur.....gms. 20 (℥v).
Glycerine.....gms. 50 (℥jss).
Pure con. acetic acid.....gms. 10 (℥ijss).

Apply locally to each wart.

They dry up, become bluish and drop off. Continue this for several days. In mollusciform nævi electrolysis is the best treatment, except when the tumors are voluminous, when the galvano-cautery or caustic may be used.—*Clinique.*

TINCTURE OF CANTHARIDES FOR EPITHELIAL NEPHRITIS.—Prof. E. Lancereaux, Paris, physician to the Hotel-Dieu Hospital, has long paid close attention to kidney disorders. In 1867, he differentiated and demonstrated the lesion of interstitial and epithelial nephritis. Subsequently he promoted the division of the interstitial form into a number of groups.

The epithelial form he divides into *toxic nephritis*, *pyretic nephritis*, and *nephritis a frigore* (large white kidney). Struck by the inefficiency of iodide of potash in these forms, especially when anasarca was present, he sought other remedies.

He says: "As pathological anatomy teaches us that anuria results from the tumefaction of the epithelium of the tubuli-contorti, I was induced to choose tincture of cantharides as an agent capable of modifying these conditions. It has already been used in some other affections of the kidneys, and its action on the epithelium of the tubuli-contorti has been demonstrated by experiments. The excellent results which I have obtained induce me to bring it under the notice of physicians. The following cases, selected from others, will demonstrate the efficacy of the medicine."

There are given notes on two cases of nephritis. One of six months' standing came into his hands after taking other treatment without help. The quantity of urine was 20 to 26 ounces daily, high sp. gr. and much albumen, hyaline and epithelial casts. There was marked anasarca. Purgatives, digitalis, milk diet, etc., gave little relief. Tincture of cantharides was then used, beginning with six drops, increased two days later to ten drops in twenty-four hours. In three days the urine increased 25 to 100 ounces. On the fifteenth day the anasarca had disappeared. At the end of six weeks the patient was discharged. The albumen entirely disappeared within six months, and at intervals during the succeeding four years, examinations showed her to be perfectly well. A second similar, but more recent case is given.

The author concludes that cantharides is a valuable agent in the treatment of epithelial nephritis. It "acts directly upon the lesion of the secretory elements of the kidneys," and does not prevent the use of drastics as soon as the phenomena of anto-intoxication appear.—*Columbus Med. Journal.*

PAPAYOTIN AND CARBOLIC ACID IN DIPHTHERIA.—Levy and Knopf have carried out experiments to show the solvent action which the ferment papayotin has upon diphtheritic membrane. This they found considerable; and by combining it with an antiseptic such as carbolic acid, the latter was enabled to penetrate more deeply, in its turn destroyed the bacilli, and gave an opportunity to papayotin to weaken the chemical poison produced by the bacilli. The addition of carbolic acid to papayotin does not destroy its digestive power. The solution used therapeutically consists of ten per cent papayotin and five per cent carbolic acid, and is applied by brush to the membrane every ten minutes for the first two hours, and after that every two hours as much as possible, and likewise during the night. The diphtheritic membrane should be brushed gently, and no attempt made to detach it. The result was satisfactory, the membrane becoming smaller, and disappearing. Sometimes it recurred, more especially where the application was left off during the night. Cases of diphtheria with tough membrane and slight infiltration in the neighborhood were more amenable to this treatment than those with great infiltration and slight membrane. Fifty one cases were treated in this way, and thirty-six of that number were recoveries. More recently they have made experiments with the nonpoisonous thymol, instead of carbolic acid, in solution 2 in a 1000, and have had satisfactory results.—*Berlin klin. Wochenschr.*—*The Practitioner.*

SALICYLIC ACID FOR CORYZA.—Dr. A. J. Wegg, of Spanish Town, Jamaica, deems salicylic acid, when employed as an errhine, a reliable agent for the arrest of coryza. A few drachms of the dry acid are placed in an ordinary paper pill box, in the cover of which small pinholes are made. Before using, the content of the box is shaken, and then the nostrils applied to the openings. This may be repeated time and again until sneezing is induced, as demanded, or as indicated by the amount of hyperæmia of the nasal mucous membrane.—*Med. Age.*

CALOMEL AS AN ANTIPYRETIC.—In a paper before the late Pan-American Medical Congress, Drs. R. J. Nunn and A. D. Simmons advocated calomel as an antipyretic especially advantageous in typhoid and continued fever. They drew the following deductions:

"Calomel is a sure and safe antipyretic, reducing the temperature from two to three degrees in a few hours.

"Small doses are of no avail.

"The ingestion of large doses is followed by no untoward event, no ptyalism, no hypercatharsis.

"Diarrhœa, hæmorrhage, albuminuria, and tympanites are not contraindications to its use.

"Even where there is no cathartic action induced it insures reduction in temperature.

"Calomel acts best in combination with soda, bismuth, and pepsin.

"In some instances the remedy cuts short an attack; in others while it may have no influence on the temperature *per se*, it modifies the system and by keeping febrile activity in check aids materially in the management of the case.

This coincides largely with our own experience, save that we fail to see any special advantage in combining calomel with soda, bismuth and pepsin; indeed, to a certain degree bismuth is contraindicated in connection with calomel, and it certainly will inhibit the action of pepsin. Calomel is best administered with monobromate of camphor, the dose of the latter being regulated by that of the former. Even forty grains of mercurious chloride is no contraindication from point of size of dose. The results are much more satisfactory than when smaller amounts are ingested; there is absolutely no danger of salivation unless administration is followed by large quantities of acid; there is no nausea induced and as Drs. Nunn and Simmons remark, no hypercatharsis. On the contrary the action is thorough and prompt, free from all discomfort. Again the ingestion of a single large dose accomplishes much more than can be obtained by a series of small doses distributed over several days.—*Editorial in Medical Age.*

INJECTIONS OF GLYCERINE AS AN OXYTOCIC.—Dr. Clifton Edgar (*Wiener med. Presse*) speaks highly of

intrauterine injections of glycerine as a simple and efficient means of producing contractions of the uterus. According to Pelzer's suggestion he injected, in two cases, fifteen grammes (four drachms) between the membranes and the uterine wall. One was a case of contracted plevis and the other a placenta prævia. In one case good contractions set in, in two and a half hours, and in the other in thirty minutes. Of course, previous antiseptic irrigation of the vagina is to be done. In the latter case a Barnes' dilator was introduced into the cervix. A catheter is attached to the end of a syringe and after introduction of the catheter into the cervix the glycerine is injected between the membranes and uterine wall.—*Lancet Critic.*

Diseases of Women.

THE THERAPEUTICS OF ABORTION.—The question whether active interference is justified or not in the treatment of abortion has not yet been settled. In every case the three chief symptoms, hemorrhage, pains and changes in the cervix uteri, should be considered before reaching a decision. Sometimes the one, sometimes the other symptom predominates. In the first place we must determine whether it is still possible to prevent abortion. This seems probable so long as the uterine neck is still impervious to the finger and the hemorrhage has not assumed dangerous proportions.

If the bleeding is not severe nothing is required; neither tampons, cold, nor ergotin should be employed, as their use would interfere with the purpose in view.

Eight days after the last hemorrhage the patient may leave the bed.

In cases where abortion is inevitable the bleeding first of all must be stopped. In Schauta's opinion immediate and thorough evacuation of the uterus is a wrong procedure. If the hemorrhage is moderate, tamponing with iodoform gauze is indicated; a strip two meters long and of the breadth of three or four fingers is introduced into the fundus of the vagina which is firmly tamponed, the end being allowed to hang from the vulva. This gauze tampon may be removed entire, while cotton tampons require repeated introduction of the fingers.

As to the time of the removal of the tampon, this will depend upon the appearance or increase of the labor pains. If they have increased to such an extent as to lead to the belief that the ovum has been detached, the gauze may be removed. Not infrequently the ovum is found lying behind the tampon.

If the contractions have not attained sufficient intensity the gauze is allowed to remain for twenty-four hours, when it is withdrawn so as not to give rise to infection.

If an examination be now made we find the os has enlarged or is still narrow, and that hemorrhage has ceased or still exists. If no hemorrhage is present and the os has not widened to any extent, the indication is to wait. If the os has, however, considerably enlarged, while the ovum is not yet detached, it is best to again tampon to prevent a renewal of the bleeding. In case the os is still narrow the tampon should not be renewed, as it is possible that abortion, which at first appeared inevitable, may not occur.

If it appears necessary the tamponing may be repeated for several days. An active course, however, should be pursued if the os opens considerably under the tamponing, and becomes pervious to at least two fingers. Under these circumstances nothing would be gained by keeping up the tampons. Two fingers are passed into the uterus which is steadied by the application of the other hand to the abdomen. The ovum is then carefully and slowly detached, or if free in the uterine cavity it can sometimes be simply expressed. If the os is too narrow to admit passage of the ovum, the latter is grasped at its lower portion with a dressing forceps and extracted. If bleeding is still present, the entire uterine cavity is tamponed with iodoform gauze in the same manner as the tamponing of the vagina. This tampon should not be allowed to remain for more than twenty-four hours.

The treatment of incomplete abortion is very difficult. It may happen that the entire ovum is still in the uterus and the os insufficiently dilated, or a portion of the ovum may have been discharged, while another has been left back. Whether the entire ovum or its greater portion be still in the uterus may be determined by observing the size of the organ.

If the size of the uterus leads one to believe that the entire ovum is still in it, the treatment should be as above. If only fragments remain, dilatation of the cervix should be practiced with Hegar's stems, the finger introduced, and the residue removed, but if the mass be so small as not to be readily removed with the finger, the curette may be employed.

If hemorrhage persist for weeks or months after an abortion, this indicates that fragments of the placenta have been left behind which should be removed in the manner as those of the ovum. In other cases of this kind, however, the condition is one of extra-uterine pregnancy with tubal abortion. Here the supposed fragments of the ovum are actually the expelled decidua of the uterus, after the expulsion of which there is a cessation of the hemorrhage which recurs the more violently after a few days. On examination a tumor of soft, doughy consistence is found at the side of the uterus. In these cases dilatation and curetting of the uterus would be followed by marked hemorrhage from the tube, and either a hematocele or hemorrhage into the abdominal cavity might occur.

Habitual abortion is frequently produced by a hypertrophic endometritis or a retrodisplacement (especially retroversion) of the uterus, chronic cardiac or renal disease also give rise to it. The most frequent cause is syphilis. Each of these conditions requires special treatment.—*Allg. Wien. Med. Ztg.—Centralbl. f. d. gesam. Therapie.—Int. Jour. of Surg.*

FOR OBSTINATE VOMITING OF PREGNANCY.—Fluid extract of golden-seal has, according to Fedorow, proved to be an excellent remedy in the treatment of obstinate vomiting of pregnancy, and has been used with excellent success. Fedorow prescribes twenty drops of the fluid extract four times daily.—*Therp. Monatsch.—Med. and Surg. Rep.*

A UNIQUE VAGINAL ATRESIA.—On the 14th of August, Mrs. H. came to me for relief from pains in the lower abdomen. These being periodical, suggested examination of the uterus. Before doing so, my patient, a young, healthy, married woman, gave me a history of perfect health till her recent marriage. Since that event, she had suffered from difficulty and distress in coitus, and from this inferred that she was different from other women. At the time of consul-

tation, she had missed one menstruation, and was complaining of morning sickness, and suspected pregnancy in consequence. On examination, the external parts were found normal. But an attempt to pass the finger into the vagina developed the fact that it was firmly vaulted over in its middle third by a fleshy mass, a partition as it were (and so it proved eventually to be), and about one-half inch in thickness. *Per rectum*, I discovered an enlarged uterus; and on resorting to a speculum to more closely determine the vaginal condition, found it of that darkened hue, dubbed "port wine color." The inference was that she was pregnant. But *how?* And it was only on a most careful inspection, that a minute central canal could be made out, through which a very fine probe passed with difficulty.

An operation was proposed and agreed to; and the following day a dissection upward defined the bridge, which was carefully cut away, exposing the upper third of the vagina, fairly normal, and the cervix of the gravid uterus in plain view, though smaller, and not distinctly protruding into the vagina, as is usual.

The patient was kept in bed two weeks, and sedatives given to insure local rest, so that now she is in good health, shows no tendency to miscarry, and will probably carry her unique conception to the usual conclusion.—*Boyes, in Canada Lancet.*

THE BINDER IN CHILDBED.—Windmüller, *Centralbl. f. Gynäk*, recently opened a long and instructive discussion on the management of normal labor and childbed. He had conducted over a thousand labors in private practice alone in the course of thirty years. He wraps flannel round the body, but objects to the abdominal binder, which he finds interferes with the functions of the intestines, checks involution of the uterus, and is in the way during ablution. For the first three days he limits diet to milk, bread and butter, rice, spinach, potatoes and fish. He forbids wine and coffee, and believes, with Zweifel, that errors in diet are among the chief causes of prominent abdomen. The patient is kept on her back for three days, but Windmüller holds that ten days' rest in bed is sufficient. He has had no cases of prominent abdomen in any of his patients, even in multiparæ, with the exception of those who had grown fat. In the discussion, several experienced obstetricians differed as to whether prominent abdomen was due to deposit of fat in the parietes after labor, or to distension of the intestines which could be controlled by the binder. Many surgeons applied no bandage after abdominal section; but the physiological conditions were then not the same as in the puerperium. Schrader and others believed that the binder did more good than harm; he laid great stress on diet in childbed as influencing the future form of the abdomen. All food liable to cause flatulence must be avoided; spinach and potatoes were particularly bad in this respect. When the pelvis was narrow, or its angle too acute, the chances of the abdomen becoming pendulous after labor were great. To counteract the evil, a good abdominal binder should be worn during the last months of pregnancy. In Japan it was customary for women to wear a binder during the entire second half of gestation. The binder in pregnancy supported the anterior walls, and greatly diminished the chances of parting of the recti.—*British Medical Journal.*

SUPERNUMARY MAMMÆ.—A short time ago a woman about nineteen years of age came to me, and said that she had a wart she would like to have taken from her right arm, which had been bothering her for two weeks. Upon examination I found that her clothes were saturated with a fluid, a good deal like milk. I noticed a tumor there about the size of a strawberry. Upon examining her other arm, precisely at the same spot, was a little bit of a tumor which looked something like a wart. She said that both of these little tumors had been there all her life, but this one under the right arm began to grow when she was about thirteen years old, and that during her pregnancy it had grown to the size of a nail. —*Shaw, in Pitts. Med. Review.*

INTRAUTERINE USE OF THE GALVANIC CURRENT IN NORMAL PREGNANCY, WITHOUT INTERRUPTION OF GESTATION.—Dr. Harn, in a discussion on "The Relative Fœticidal Value of the Galvanic and Faradic Currents in Ectopic Gestation," at the October meeting of the American Electro-Therapeutic Association held in New York (*Am. Gyn. Jour.*), says that he made an intrauterine application with a current of forty milliampères in a woman who was not known at the time to be pregnant, wherein the pregnancy continued uneventfully till the seventh month, and eventuated in the birth of a living child.

I had a similar experience with an equal number of milliampères. Two applications were made at about the second month, and yet pregnancy went to full term.—*Jour. of Bal.*

THE DRAINAGE OF PYOSALPINX THROUGH THE UTERUS.—In a paper read before the American Gynecological Society, Dr. Murray joins with Dr. Polk and others in claiming that pyosalpinx can be cured without resort to removal of the offending organ. The patient must be anesthetized, the uterus dilated, and then thoroughly curetted. He formulates the following conclusions:

1. That many cases of pyosalpinx are curable without mutilating operations if the endometritis be treated by curettage and drainage with strict antiseptic precautions.
2. That uterine curettage and drainage should be practiced in every case before operation unless the tubes are very distended and thin, to cure the endometritis which may be and often is cause of trouble and of the lack of relief after cœliotomy and removal of the organs have been performed.
3. That even after pyosalpinx frequently the tubes and ovaries are not useless organs, the proof being that pregnancy occurs and the puerperium is normal.
4. That only after proper treatment, the tubes, ovaries and uterus still remaining bound down by adhesions and continuing a menace to life and health, should the radical operation be done.—*Pacif. Med. Jour.*

PESSARY INCARCERATED IN THE UTERUS.—A woman, aged 77, applied for relief at Professor Schauta's clinic in Vienna last April. She suffered from dysuria and sanious purulent vaginal discharge. She had borne sixteen children, without instrumental delivery; in 1839, after her second labor, a prolapse developed. Five years ago she was supplied with a Breisky's egg pessary, which she took out and cleaned till five months ago, when it slipped up out of reach. She

was hale and muscular. The vagina was unusually long; the os uteri admitted one finger, its borders were very tough. The lower pole of the pessary could be felt a quarter of an inch above it. The instrument clearly occupied the cervical canal; the body of the uterus was detected capping its upper pole an inch above the pubes. The patient was narcotized. A small incision was made on each side of the os. Then a hole was burnt in the pessary with a Paquelin's cautery, and the point of a stout tenaculum fixed into the hole. Two more holes were burnt into the instrument, so that the points of a polypus forceps could be fixed into them. A big piece of the pessary came away. After tedious *morcellement* the entire pessary was removed; its short diameter was two and one half inches. The walls of the cervix were extremely thin; the uterine cavity above it measured four-fifths of an inch. A tampon was applied to the cervix and vagina. Three days later the os had contracted to its size before the operation.—*Brit. Med. Jour.—Pacif. Med. Jour.*

Report of Case of Twin Pregnancy with Distinct Placenta, One of which was a Placenta Prævia.—I was called to see Mrs. L., aged 31, multipara, whom the messenger said was "about to be confined." Upon my arrival I found patient suffering but little, only "sharp, cutting pains" as she described them; on examination I found considerable hæmorrhage, and the os but slightly dilated, if at all; she thought she was not more than six or seven months in pregnancy. I prescribed for her, and left, with instructions that I be called should any alarming symptoms appear.

Late in the afternoon of the 27th, I was hurriedly called, and upon my arrival found her suffering greatly, and upon examination found the os dilated to about the size of a silver dollar, and a very profuse hæmorrhage. I saw at once that premature labor was inevitable.

Upon my second examination I found the os more widely dilated, and introducing my fingers, I felt a thick membrane of some kind protruding, completely enveloping the internal os. The hæmorrhage was so great that it ran through the bedding and stood in a pool upon the floor. The patient was very weak, vomiting severely and frequently; she would faint, so to speak, and appear almost lifeless. I saw at once something must be done, so introduced my whole hand into the vagina, and my fingers into the internal os, and detached the thick membrane from the walls of the uterus all around, and then the second or third pain expelled the membrane, which proved to be a placenta, and the following pain expelled the fœtus, (male) which was dead, and looked as though it had been carried to maturity, as regards size and development. The patient was still suffering greatly, and to my surprise, on examination, I found another fœtus with a foot presentation; the second fœtus was delivered, also dead. I severed the cord and extracted the placenta, which was attached to the fundus of the uterus. Now I had two fœtus, two distinct placenta and cords. After washing out the uterus thoroughly I left, and returned in a few hours to find patient resting quietly, and to-day she is enjoying her usual good health.

This case, no doubt, is of rare occurrence, I have neither read or heard of a case as this was.

In speaking of fœtus number two, I neglected to say that it was a female, and about half the size of the first one, and I am unable as yet to satisfy my mind as to what stage of pregnancy she was in at the time.—*Dr. Turk in So. Med. Record.*

The Disorders of the Nervous System Associated with the change of Life.—Dr. Gustavus Eliot in concluding this article offers the following proposition:

1. At the time of life when the menopause occurs the various organs of a woman's body are likely to be in a state of depression as regards either their nutrition or functional activity, so that the normal equilibrium of health action may be easily disturbed, and abnormal action, the manifestation of disordered function, may be inaugurated and perpetuated.

2. The cessation of menstruation is an event of great physiological importance, and is perfectly competent to produce grave disturbances of the nervous system, if any predisposition to them already exists.

3. The more common disorders of the nervous system occurring under these circumstances are functional in character, and are associated with disturbances of functions of other organs, and especially of the digestive, circulatory, and hematopoietic systems.

4. In their treatment, attention should first be paid to improving the general nutrition of all the tissues of the body, and restoring each organ to its normal activity.

5. If, after all other organs have resumed the proper performance of their functions, symptoms referable to a disordered condition of the nervous system still persist, recourse must be had to remedies which act directly upon the nervous system, either by improving its nutrition or by modifying and regulating its action.—*Med. and Surg. Reporter.*

The Significance of Vaginal Discharges.—A leucorrhœa inodorous or of mild odor persisting during the climacteric, accompanied by increasing hæmorrhage, is suspicious and demands investigation. A leucorrhœa profuse, of peculiarly fetid odor, grumous, excoriating, appearing early or late during the climacteric, with profuse hæmorrhage, is reasonable evidence of cancer of the cervix. A leucorrhœa moderate in amount, ill-smelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hæmorrhage suggests cancer of the corpus uteri. A leucorrhœal discharge with hæmorrhage, containing material like the washings of meat is said to indicate sarcoma. A watery discharge, as a rule, occurring during menstruation, odorless, or of little odor, persisting, accompanied by profuse hæmorrhage, indicates fibroids with little or no hæmorrhage, polypi. Profuse bloody discharge coming on gradually with declining menstruation, ceasing usually with the menstrual flow, point to fibroids. Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring as a rule after the menopause, indicate cancer. A gradually increasing amount of menstrual flow is suspicious and needs investigating. Post-climacteric hæmorrhages in a fibroma of the uterus of long standing form one of the principal grounds for the suspicion of sarcoma (Borner). The early recognition of malignant disease is demanded, and possible prevention of the fatal exhaustion which accompanies it by the administration of drugs, and the application of those methods which in a measure may be supposed to offset the terrific drain on the nervous system; inas-

much as present experience shows that early removal of diseased tissue prolongs life, the importance of early diagnosis and treatment can hardly be overestimated.—*New England Medical Gazette.*

Uterine, as a Cause of Breast Disease.—Dr. Routh sent to the International Congress at Brussels, a brief resumé of three cases illustrating the relation of the uterus as a causative of breast disease. In the first there was immense hypertrophy of the parenchyma of both mammæ from uterine irritation; the second, hypertrophy of the cervix, in whom both mammæ were as big as a man's head, but large from the size of the lacteal tubes, and not involving the parenchyma. Amputation of the cervix immediately brought about absorption of the mammæ to their normal size. The third was a well-marked cancer of the breast, which he amputated. But although the greater part of the wound healed, for weeks small cancerous points kept cropping up. The other breast becoming painful, Dr. Routh insisted upon a vaginal examination, and found the uterus intensely ulcerated inside the cavity and outside on the cervix. He cured the ulceration, and no further cancerous points made their appearance. He considered, therefore, that in all cases of mammary disease the uterine organs should be examined, and treated if found diseased. Baker Brown believes that many cases of enlarged breast could be traced to irritation of the vulva or cervix uteri.—*The Brit. Gyn. Journal.* —*Char. Med. Jour.*

The Relations of Operative Gynæcology to Insanity.—In the *Annals of Gynæcology and Pædiatrics*, Dr. A. H. McFarland in an article on this says:

The chief medical error of the present day is the mistaking of brain disease for pelvic disease, and the prayer of the neurologist in behalf of the neurosthenic woman is for rest for her whole organism from needless irritation and unnecessary gynæcological operative disturbances. This does not include a protest against the treatment of the real consequences of gynæciac disease, nor of those uterine disorders which are the result of neuropathic disorder, the hyperæmias, hyperplasias, morbid growths, grave traumatisms and displacements. These are surely numerous enough to keep gynæcologists employed.

The day of gynæcological errors is waning; a light shines from behind the cloud. It is the ray of the neurological sun. Through the clouds day dawns for woman's emancipation from the misery of medical error, and a true neurological gynæcology is born into the family of clinical and therapeutic science.

Conclusions. — 1. Gynæcological operations are more likely than any other surgical procedures to disturb the mind.

2. Hereditary antecedents of the patients should always be determined.

3. In insane patients operations should be performed only when the physical condition endangers or renders life insupportable.

4. Patients, precedent to the operation, should be in a calm frame of mind—hence, moral treatment of the patient previous to operating is the best prophylaxis.

5. Inherited and acquired insane constitution is the fundamental factor in most cases of insanity. This conclusion does not, however, justify us in ignoring physical diseases immediately preceding or associated with insanity.

6. Healthy genital organs do not give rise to reflex symptoms, consequently caution should be exercised in operating for the relief of insanity.

7. Operations may be satisfactory in properly selected cases.

Relation of the Vaginal Secretions to Puerperal Fever.—(*Zeitschr. f. Geburts-Nülfe*). Döderlein examined the secretions in 195 cases of pregnant women with reference to the presence of pathogenic organisms. In normal secretions only fission fungi were found while bacilli and cocci occurred in great number and variety in those of disease. The percentage of healthy cases was 55.4 per cent, of pathological 44.6 per cent. In primiparæ the proportion of normal cases was a little larger, amounting to about 64 per cent. The author suggests the litmus reaction as a ready means of distinguishing healthy from morbid conditions of the vaginal secretions. Normally the reaction of the vaginal mucus is strongly acid, while in disease it is faintly acid, neutral or alkaline. Experiments show that the acid condition of the vaginal secretions is produced by the innoxious organisms which have their habitat in the healthy vagina. The author found by culture experiments that these organisms when present in great abundance, were inimical to the growth of the staphylococcus. A similar observation has been made by Bumm.

The author's conclusions for the practical obstetrician are to the effect that in women whose vaginal secretions present the normal litmus reaction, a feverless childbed is assured, provided they escape infection from without.

In morbid conditions of the vaginal secretions pathogenic organisms are liable to be transported into the uterus on the examining finger. Without internal manipulation of any kind during labor the danger of infection is almost nil.

In private practice it is generally impracticable to distinguish between healthy and morbid vaginal secretions. The prophylaxis for every case must be such as to protect against all possible sources of infection.

In hospital clinics the litmus reaction serves to separate the diseased from the normal cases.

Antiseptic irrigation of the vagina for disinfection is not reliable. The irrigating fluid does not penetrate all the folds and recesses of the passages. Steffeck and Döderlein have practiced irrigation combined with thorough friction with the fingers, and lubrication is re-supplied by rubbing the vaginal surfaces with mollin.

For diseased cases they recommend the use of the disinfectant douche during the latter weeks of pregnancy as more satisfactory than attempts at sterilizing the passages during labor. A 1 per cent solution of lactic acid answers the purpose. The secretions gradually take on a healthy character. The douching is discontinued when the litmus test gives a constant acid reaction.—*Brooklyn Med. Jour.*

Conception during the Puerperal Period.—Brasseur quotes the case of a woman, aged 22, who was delivered on July 4, 1892, of her first child. July 8th she indulged in sexual intercourse, and was delivered, March 10, 1893, of a child measuring 52 centimeters in length and weighing 3,550 grammes. Calculating

from the date of coitus, the second pregnancy lasted 243 days, that is, twenty-seven less than the normal.

Ovulation must have existed in the woman on the fourth day after the delivery, and it was necessarily quite independent of menstruation. Koenig draws from the foregoing the following deductions:

1. A gestation period of 243 days after a fecundating coitus may produce a viable child.

2. The spermatozoa can live in the lochial secretions.

3. The functional activity of the ovaries is not completely suspended during pregnancy. The Graafian follicles so open that they may burst a very short time after delivery.

4. Ovulation and menstruation may occur independently of each other.

5. Among vigorous women during the period immediately following confinement, the uterine mucous membrane may undergo a rapid regeneration which renders possible the implantation of a fecundated ovule immediately after delivery.—*Gazette Médicale de Liége.—Med. Age.*

Diseases of Children.

How to Incise Post-Pharyngeal Abscess in Children.—Compression of the trachea in the neck may be caused in children by abscess, by enlarged glands, by goiter, or by a foreign body impacted in the œsophagus. Abscess in the neck, producing compression of the trachea or inflammatory œdema of the glottis, is most likely to be post-pharyngeal in position. The advantage of opening a post-pharyngeal abscess by incision in the neck and not within the mouth is now fully recognized, particularly if the abscess is dependent on vertebral disease and the discharge is likely to be continuous. If the difficulty of breathing is urgent, and the dissection from the neck likely to be too prolonged, tracheotomy will be advisable as a first step. Intubation would seem to be contraindicated by the possible alterations in the relations of the larynx and trachea. If, however, the abscess is small and there seems to be a difficulty in getting at it from the side of the neck, a vertical incision may be made from the mouth; but care should be taken to bend the child's head quickly forward so that the pus may run out of the mouth. If radical treatment is postponed, pressure symptoms may become urgent, or rapid œdema of the glottis may arise, or the abscess may burst spontaneously and death take place by suffocation, particularly if the abscess should burst while the child is asleep. In children under a year old these abscesses do not often depend on cervical caries, but arise from causes which produce similar abscesses elsewhere, such as inflammation around the lymphatic glands in front of the vertebræ; or they are secondary to tonsillitis, disease of the ear, or after catarrhal conditions of the posterior nares and fauces. In 204 cases, which were recorded by Bokai as occurring in the Children's Hospital at Pesth, only seven were secondary to caries of the vertebra.—*Lancet.—Lancet-Clinic.*

Gonorrhœa Occurring in Little Girls.—Dr. Cassell, the author, has examined the discharge of pus from the genitals of thirty small girls and found gonococci in twenty-four. The youngest of these was seven months and the eldest eleven years. In the greater number of cases the author was able to trace the infection to other members of the family. Dr. Cassell does not favor the idea that all these cases were infected by direct means, but believes that this class of people living in close quarters, may contaminate each other by means of bed linen, sponges or body linen.

The diagnosis is of importance. In all cases of gonorrhœal vulvo-vaginitis there was free discharge, and thick, creamy, greenish-yellow pus.

Therapeutically, the author treats the patients by local and general baths, placing the pelvis high for local injections, for which he uses an ear syringe containing 1 to 2,000 of sublimate solution daily.

If the discharge becomes less profuse after two or three weeks, he uses two to three times weekly, a one to a one and a half per cent solution of nitrate of silver; these are continued until the cure is established, which usually occurs between two and three months.—*Berlin klin. Wochen.—Med. and Surg. Reporter.*

Congenital Cirrhosis of the Liver.—Neumann (*Berliner klinische Wochenschrift*, May 8, 1893) reports a case of congenital cirrhosis of the liver. The patient was a girl of four months, who had suffered from birth with jaundice. The skin and all mucous membranes were deep yellow, the general condition was bad, the child took little nourishment and passed infrequent stools without the slightest yellow color. Treatment was of no avail. Liver and spleen were both enlarged. After death all organs were found normal except spleen and liver, which were enlarged and hard; the gall bladder was empty. Microscopic examination showed a cirrhotic condition of the liver tissue. The gall ducts were patulous, but empty. The patients were syphilitic and the mother also tuberculous.—*Annals of Gyn. and Pæd.*

Chlorine Water in Diphtheria.—Ellis (*British Medical Journal*), has used a solution of chlorine gas in 200 cases of diphtheria with excellent results. He prepares the solution by placing twenty to thirty grains of potassium chlorate in a *dry* eight-ounce bottle and pouring upon it ten minims of hydrochloric acid. The bottle is filled with water after all the gas is evolved, and the whole well shaken. The mixture is made palatable by the addition of glycerine. It may be diluted for very young children. If the child is too young to gargle, a few drops may be given every half-hour. It is most efficacious when used as a spray.—*Annals of Gyn. and Pæd.*

Therapeutics of Pneumonia in Infancy and Childhood.—Jacobi (*Archives of Pædiatrics*, April, 1893), speaks as follows concerning the treatment of pneumonia at this period of life: Labor cases should be isolated. Early calomel purgation is valuable in many ways. Temperature is to be interfered with only when it causes untoward symptoms. Phenacetin, antipyrin and acetanilid have more frequently lowered the temperature than saved lives. He recommends quinine during the remissions. Cold, from its refrigerant and stimulant action, is the best antipyretic, especially in the form of the cold pack, for twenty to forty minutes, on chest and thighs, with the arms left out; ice may be rubbed over the surface of the pack. In anæmic babies the pack should be tepid. Alcohol is not needed at first, as a rule. A few full

doses of digitalis is better often than its continuous use.

Insufficient peripheral circulation with small pulse demands a vasodilator with the digitalis, and nitroglycerine, gr. $\frac{1}{100}$ to $\frac{1}{100}$, or sodium nitrite, gr. $\frac{1}{10}$ to $\frac{1}{4}$, may be given hourly or bi-hourly. Aconite at this juncture may be very valuable in half-drop or drop doses, with or without digitalis, every two or four hours. A strong mustard bath for the feet may at times be invaluable.

Oxygen inhalations through the nose may be of service in gaining time. When direct stimulation of the heart is required strychnia may be used hypodermatically in doses of gr. $\frac{1}{100}$, repeated; or ammonium carbonate, gr. ½ to gr. 1, every half, one or two hours. Camphorated oil, 20 per cent, hypodermatically, in six to twenty minim doses, will prove most efficient. During the period of incipient resolution, with insufficient expectoration, steam, with or without turpentine, may be employed, or teaspoonful doses of camphor water or carbonate of ammonium. Ten to twenty grains of ammonium chloride, volatilized over a flame, will stimulate the bronchi more effectively than its internal administration.—*Annals of Gyn. and Pæd.*

ENTEROCLYS IS IN THE SUMMER DIARRHŒA OF CHILDREN.—MÜLLER (*Therapeutic Gazette*) reports seventy-eight cases of summer diarrhœa treated by enteroclysis in conjunction with other hygienic and remedial measures. His conclusions are as follows:

1. That intestinal irrigation may be considered a valuable adjunct in the methodical treatment of suitable cases of summer diarrhœa.

2. That irrigation with cold or ice water will lower the temperature of the lower portion of the abdomen by direct refrigeration of the blood mass, and that the procedure is indicated when high temperature lasting for a considerable time endangers life by coagulating the cerebral fluid of cardiac protoplasm, or when accumulation of feces, mucus, etc., in the bowel causes a continued irritation of the mucous membrane.

3. *That the dangerous effects of the poisonous animal alkaloids are diminished or contracted or dissipated by irrigation.*

4. That the influence on the circulatory apparatus is shown by the change in the pulse, which becomes less frequent and stronger.

5. That systematic enteroclysis results in an amelioration of the symptoms and a shortening of the course of the affection, and will often overcome the semiparalytic condition of different organs.

6. That the resistance which the fever offers to its reduction by this method in an index of the gravity or mildness of the case.

7. That alcoholic stimulants are of importance in the treatment of summer diarrhœa in children.—*Univ. Med. Mag.*

Toxicology.

ACUTE IODISM.—Dr. Wm. Logie Russell reports the following (*Med. Rec.*): The following case is of interest because, so far as I am aware, no death from iodism has previously been reported.

The patient, a man sixty-eight years of age, was seen in consultation with Dr. Wm. S. Moore. He was of robust physique and enjoyed fair health with the exception of rheumatoid arthritis, with which he was affected. A slight exacerbation of this trouble had led him to call in a dispensary physician a few days before. The following was prescribed:

℞. Syr. ferri iodid.....3ij.
Potass. iodid.....3j.
Syr. simplicis, ad.....℥iv.
M. Sig.: 3j. t. i. d.

One teaspoonful of this was given on the first day, two on the second and two on the third. By this time the symptoms of iodism were so intense that the medicine was discontinued, and Dr. Moore sent for. A profuse coryza and conjunctival congestion were then present. So intense were these that hemorrhages occurred from the nostrils and eyelids. The skin had at this time a mottled hue, and bullæ were found on the face, scalp, neck, chest, arms, hands, legs and feet. Some of the bullæ were as large as a silver dollar, and contained sanious fluid. The eyelids ulcerated and became so swollen and covered with crusts as to conceal the eyeballs. The nostrils were completely blocked with crusts. The mucous membrane of the mouth and throat was inflamed and eroded, swallowing being painful and difficult. The voice became husky, and at last sank to a whisper and disappeared. Superficial ulcerations took the place of many of the bullæ. There were no gastro-enteric symptoms. The urine was not examined. The mind was clear, and there was no neuralgia.

The patient remained as described above for several days. He died on the tenth day from the administration of the first dose, from inanition and a low grade of pneumonia. There was no autopsy.—*St. L. Med. and Surg. Jour.*

ANTIDOTE FOR CARBOLIC ACID.—An Italian tailor swallowed by mistake thirty grammes of carbolic acid. Dr. Moreit, of Ancona, using a rubber catheter, immediately introduced by slow degrees into the patient's stomach a strong solution of sulphate of soda, which forms with carbolic acid a harmless mixture. In an hour's time the patient, who had been in a critical condition, began to revive. Inhalations of ammonia were then used to hasten up the process, and little by little the poisoned man rallied so that an emetic, followed by a dose of lime water, finished the cure.—*Medical Times.*

DEATH FROM INJECTION OF MERCURIAL OIL.—Among the many preparations of mercury designed to replace the mercurial ointment, Lang's oleum cinereum, a suspension of oil in mercury has had considerable popularity in Germany. In 1889, Lukasiewicz reported a death from its use, and now Klien (Deutsche *Med. Woch.* 31, '93) publishes another. The patient, a man of twenty-six years, had received thirteen to fifteen injections in the course of two months when salivation set in, and this was followed, in spite of stopping the injections, by severe dysentery, to which the symptoms of acute nephritis were soon added. Nothing could be found to check the dysentery and the man died about three weeks after the beginning of the diarrhœa. The case emphasizes the necessity for caution in the attempt to replace the old and tried inunction cure by the more convenient but more dangerous injections. It will be remembered that deaths have also occurred from injections of suspensions of calomel. The danger of this form of treatment undoubtedly results from the irregular absorption of

these insoluble preparations. If each dose is cleared up before the succeeding one is given no trouble results; but if several depots of mercury accumulate in the body, and warning symptoms occur, the physician is powerless to cut off the supply of the poison. —*Omaha Clinic.*

MERCURIAL POLYNEURITIS.—Leyden (*Deutsche Med. Wochenschrift,* 31, '93) reports the case of a young man who after having acquired syphilis and having been treated with vigorous mercurial inunctions was seized with severe nervous symptoms, giving in general the picture of an acute tabes; severe pains in arms and legs, absence of tendon reflexes, ataxic walk, reduced sensibility of extremities. On the supposition that syphilis might be the cause of the nervous trouble, more mercury was given, but this rather made matters worse than better. Rest and expectant treatment then accomplished a cure. Leyden refers to the work of Letulle, who called especial attention to the deleterious action of mercury on the nerves, and who has found by experimenting on animals that when nerve fibers are exposed to the action of mercury a decided degeneration, increasing directly with the length of the exposure, takes place in them. Leyden also cites the cases of Forestier and Ketli. The former observed a young man who had taken much mercury for six months, on account of what, on critical examination, showed to be a very doubtful syphilitic infection. He finally developed a pronounced paralysis of all four limbs with muscular atrophy. In this case also recovery was complete. Not so fortunate was Ketli's patient. He was a physician who, by mistake, drank fifty grammes of a one per cent sublimate solution. This was followed by a severe dysentery, from which on the eighth day he had entirely recovered, when he began to complain of numbness of the extremities. Then followed the typical picture of paralysis ascendens, the limbs and entire trunk becoming paralyzed; then the neck muscles, death from asphyxia closing the scene. Leyden closes with the following words of warning: "Just in the branch of nervous diseases are medical men inclined, at present, to attribute to syphilis an important etiological role, and on this basis to prescribe vigorous and repeated courses of mercury. Tabes also is one of those diseases of the spinal cord for which mercury is often used without proper grounds. The facts herewith submitted, particularly the experiments of Letulle, are calculated to bring to mind that, in a disease in which progressive atrophy of the nerve fibers exists, the danger cannot be excluded that mercurial treatment in place of improving the trouble may hasten the progress of the atrophic process."—*Omaha Clinic.*

Otology.

DYSPHAGIA FROM AURAL DISORDER.—A case of aural reflex of unusual character, due to impacted cerumen, is reported by Dr. Samuel Theobald, of Baltimore. The patient was a married woman of fifty-two years. She had suffered from annoying cough for six months, with spells of dysphagia. These symptoms increased in severity, any manipulation of the right ear inducing an attack. A plug of cerumen, which probably had been forced down upon the tympanic membrane by unsuccessful attempts to remove it, was discovered in the right ear. It was removed by syringing, and all the unpleasant symptoms at once disappeared. Ear-cough is, of course, of not infrequent occurrence (*Practitioner,* vol., xxxviii, p. 422,) but spells of inability to swallow due to reflex aural irritation are rare. Burnett, in his work upon the ear, states that both Senac and Jissot have described cases of this character.—*The Medical Record.*

BOOK REVIEWS.

"Outlines of Practical Hygiene Adapted to American Conditions." By C. Gilman Currier, M. D., Visiting Physician to the New York City Hospitals; Fellow of the New York Academy of Medicine; Member of the New York Pathological Society; Member of the American Medical Association, etc., etc. One large octavo volume, 468 pages, Illustrated, $2.75. E. B. Treat, 5 Cooper Union, New York. 1893.

The preparation of this book was undertaken at the instance of busy practitioners and students who emphasized the lack of a compendious work upon practical hygiene, embodying the most modern truths, and which at the same time was adapted especially to American conditions. It is agreeably written and practically instructive, and upon investigation will be found to embody the results of the most profound research.

The contents embrace: Soil, Climate, Protection of body, Clothing, Bathing, Personal hygiene, Physical exercises, Schools, Occupations, Their influence on Health, Heating, Lighting, Buildings, Ventilation, Diet, Foods, their preparation and adaptation, Water and water supplies, Fluid waste, Sewers, Drainage, Plumbing, Garbage and other refuse, Disposal of the dead, Human excreta, disposal of; Bacteria and diseases, Infectious diseases, Disinfection, Restriction, Communicable diseases.

"History of the Life of D. Hayes Agnew, M. D., L. L. D." By J. Howe Adams, M. D. With fourteen full-page portraits and other illustrations. In one large royal octavo volume, 376 pages, extra cloth, beveled edges, $2.50 net; half morocco, gilt top, $3 50 net. Sold only by subscription. Philadelphia. The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

The above is an excellent sketch of the life and work of this distinguished surgeon. He was one of the few who live intensely in their work and give no thought to biographies or the hoarding of material or data for the historian. Through the efforts of his wife, and from the memory and material in the hands of his friends, this work has at length been accomplished.

With Dr. Agnew it was not one of those achievements which bore the stamp of originality which made his name a tower of strength, but other charms of social and personal life which have made his memory live long in the minds of his friends. This volume is a fitting monument to a great man.

"Manual of Clinical Ophthalmology." By Howard F. Hansell, M. D., Lecturer of Ophthalmology in the Jefferson Medical College; Chief Clinical Assistant in Eye Department, Jefferson Medical College Hospital, etc., and James H. Bell, M.D., lately Demonstrator of Anatomy in Jefferson Medical College; Member of Ophthalmological Staff, Jefferson Medical College Hospital, etc., with 120 Illustrations. Philadelphia: P. Blakiston, Son & Co. 1892. Price, $1.75.

This little work is intended as a brief review of the anatomy, physiology, refraction and common diseases

of the eye and is written in such a comprehensive manner that the student cannot fail to cull many practical hints from its perusal. The sections devoted to diseased conditions are especially well written, and are serviceable to the general practitioner who has to diagnose such cases. It is illustrated sufficiently to explain the text clearly, and is an excellent manual for the undergraduate and general practitioner.

"A Manual of Diseases of the Nervous System," By W. R. Gowers, M.D., F. R. C. P. F. R S., Consulting Physician to University College Hospital; Physician to the National Hospital for the Paralyzed and Epileptic. Second Edition, revised and enlarged. Vol. I. Diseases of the Nerves and Spinal Cord. 180 illustrations, with 370 figures. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut St.

Much delay has occurred in the appearance of the second edition of this volume, due to the great amount of work that has been expended upon it, the first edition having been thoroughly revised and some one hundred and fifty pages added. Three new sections on multiple neuritis, beri-beri, brachial neuritis, senile paraplegia, Morvan's disease, and the peritoneal type of muscular atrophy are added as well as extensive additions to the account of the functions of the spinal cord and the symptoms of its diseases, of syringomyelia, tumors, muscular dystrophy, traumatic lesions, etc. The needs of both student and practitioner have been constantly kept in view and the work as a whole is one of the most clear, concise, and complete text-books upon diseases of the nervous system that can be found in any language.

"Psychopathia Sexualis." With Especial Reference to Contrary Sexual Instinct. A Medico-Legal Study. By Dr. R. von Krafft-Ebing, Professor of Psychiatry and Neurology, University of Vienna. Authorized Translation of the Seventh, Enlarged and Revised, German Edition. By Charles Gilbert Chaddock, M D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis; octavo, 436 pages, cloth, $3.00 net; Philadelphia: The F. A. Davis Company, Publishers.

This volume is the authorized translations of the seventh enlarged and revised German edition and as a translation the work cannot be too highly praised. The task certainly presents many difficulties from the nature of the subject treated, and has been accomplished in a way to commend the book to all. The original work treats the subject with a scientific thoroughness and justice, and brings before the physician and jurist many perversions and vices of sexual life that fortunately are but seldom met with, but which it is their duty to be informed.

History and literature has been searched by the author and this volume contains everything of value to a complete consideration of this dark side of human action.

"The Elements of Human Physiology." By Ernest H. Starling, M. D., M. R. C. P., Joint Lecturer on Physiology at Guy's Hospital, London. 100 Illustrations. 12mo. 436 pages. Cloth, $2.00. P. Blakiston Son & Co., 1012 Walnut street, Philadelphia, Pa.

Dr. Starling has compiled a valuable text-book of physiology and one that will be eagerly welcomed by a large circle of students. He deserves credit for the way in which the book has been brought up to date in all its departments, and this feature renders the volume of the greatest use, not only to the elementary student, but also to the more advanced. The results of recent work are all incorporated in the text and put before the reader in the plainest possible manner.

"The International Medical Annual and Practitioner's Index for 1893." Edited by a corps of thirty-eight department editors European and American—specialists in their several departments. P. W. Williams, M. D. Secretary of Staff. 626 octavo pages. Illustrated. $2.75. E. B. Treat, Publisher, 5 Cooper Union, N. Y.

The yearly issue of this valuable reference work is to hand and it richly deserves the enviable reputation which its predecessors have made, for selection of material, accuracy of statement and great usefulness. It is divided into three parts as follows:

PART I., comprises the New Remedies, together with an extended Review of the Therapeutic Progress of the Year.

PART II., comprising the major portion of the book, is given to the consideration of New Treatment; and is a retrospect of the year's work, with several Original Articles by eminent authorities.

THE THIRD—and last part—is made up of miscellaneous articles, such as Recent Advances in Sanitary Science; Improvements in Pharmacy; New Inventions in Instruments and Appliances; Books of the Year, etc.

To the physicians who endeavor to keep abreast of the times, and who lack time to read the more elaborate treatises, these volumes present many opportunities for information, on account of their conciseness. They should find a place in every medical library.

MISCELLANEOUS.

INTESTINAL DIGESTION.—McFadgen, Mencki, and Sieber have recently reported the results of their observations upon an interesting case in the clinic of Prof. Kocher, of Berne. The patient, sixty-two years of age, had been obliged to undergo an operation for strangulated hernia, which required the removal of several inches of the small intestine at its point of junction with the cæcum, and also a portion of the cæcum. The intestine was attached to the skin, forming an artificial anus and excluding the large intestine. The following conclusions were reached by the observations:

1. The time required for food to reach the large intestine after being taken into the stomach, is from two to five hours.

2. From fourteen to twenty-three hours are required for foods not the most easily digested, such as green peas, to pass the entire length of the small intestine.

3. Fermentation of the carbohydrates takes place in the small intestine, but proteid foods do not undergo putrefaction until the large intestine is reached.

4. About eighty-six per cent of the albuminoids are digested and absorbed before reaching the ileocæcal valve.

5. The patient gained in weight, showing that the function of the large intestine is not absolutely essential to life.—*Mod. Med. and Bact. World.*

A REMARKABLE CASE OF STAB WOUND OF THE HEAD.—Dr. W. F. Brokaw reports in the *Int. Jour. of Surgery:* In January, 1892, while attending a case of injury, my attention was called by a young man present to an old wound on his head about an inch

above and two inches back of the left ear, which he said would not, for some reason, heal up.

Examination revealed a sinus suppurating slightly, and the presence of a firmly fixed metallic substance below the surface or the scalp, the scalp appearing considerably thickened and indurated around the point of injury.

Upon questioning the patient he said that in a quarrel, about six months before, he was stabbed in the head, and although the injury was very painful, and at times made him feel quite sick, yet he had not consulted a doctor in regard to it, and was not aware that there was anything in the wound. He was informed that probably a piece of the blade of the knife with which he had been stabbed was broken off in the wound.

The patient readily consented to an operation for its removal, and assisted by Dr. C. E. Cotton, he was anæsthetized and an incision made freely, exposing the broken end of the blade, which was found to be quite firmly lodged in the skull, considerable force being required to extract it. As anticipated, it proved to be a piece of the blade of a jack-knife over an inch in length, and fully half its length was buried in the skull.

There was no evidence that the skull had been entirely penetrated, however, as the bottom of the sinus was boney and no distinct history of symptoms of compression from facture of the inner table or from hemorrhage could be obtained. The skull at this point being quite thick it is probable that the brain was not reached.

Wit and Humor.

The Wrong Number.—Mistress—Who rang the bell then, Katie?

Katie— A boy, mum, lookin' for the wrong number.—*Am. Anal.*

A Plausible Derivation.—What sort of a doctor is a specialist, papa?

Pater—One who devotes himself to the acquirement of specie.—*S. and G. Monthly.*

The Reward of Wickedness.—"I never robbed a man but once," said the honest tramp, "and then I was starving. He would not give me a penny, and I couldn't stand the gnawings in stomach any longer. So I knocked him down and went through his pockets. What kind of a haul did I make? Just one little bottle what read on the label: 'Pepsin, for that full feeling after eating.'"—*Judge.*

Patient—"As we have known each other so long, Doctor, I do not intend to insult you by paying your bill. But I have left you a handsome legacy in my will."

Physician—"Very kind of you, I am sure. Allow me to look at that prescription again. There is a slight alteration I should like to make in it."—*N. Y. Med. Times.*

A Peddler once overtook another on the road and tried to pass him. This, of course, the other objected to, and a spirited altercation took place.

"What do you carry?" at length demanded number one.

"Drugs and medicine," was the reply of number two.

"All right, then go ahead," said the other, "I carry gravestones."

Pryer—"What medical college is your physician a graduate from?"

Guyer—"Medical college! Huh! He's no medical college fledgeling. He's a graduate of the jury which listened to the expert testimony in a great poison case."—*Puck.*

Physician—(with ear to patient's chest) "There is a curious swelling over the region of the heart, sir, which must be reduced at once."

Patient—(anxiously), "That swelling is my pocket book, doctor. Please don't reduce it too much."—*Our Dumb Animals.*

Interesting.—Mrs. Peachblow—"Who is that dreadful man my daughter is talking to?"

Mrs. Seteway (angrily)—"Why, that is my son!"

Mrs. Peachblow (in confusion)—"Oh, I beg a thousand pardons. I thought it was your husband."—*Truth.*

It is of a doctor, if I recall it rightly, that the following story is told: He was seated in his office, busily engaged writing. He had endured numerous interruptions, which had somewhat tested his patience, but not annihilated his sense of humor. A gentleman is announced, and walked into the room. The doctor looked up and said, "I'll be through in a moment, sir; take a chair, please." "Sirrah!" said the pompous individual who had entered "do you know who I am? I am the Lord Viscomte de Bourneville!" "Is that so?" said the doctor. "Well, then, take two chairs."—*St. Louis Clinique.*

A Hospital Patient's Soliloquy.—Overheard by a rhyming probationer:

I've had the typhus fever, and water on the brain,
I've had the influenza, and suffered awful pain;
I've had the yellow fever and scarlatina, too,
I've had the collywobbles, but the doctor pulled me through.
Of course, I've had the measles, the worms and the croup,
I also had a dreadful cough accompanied by whoop;
I've had the jaundice more than once,
Carbuncle, whitlow, boils;
But when I think of any more
My memory recoils.
But still I'm bound to tell the truth
And give an honest answer,
I know the next will take me off,
And that will be the cancer.

—*Hosp. Gaz.*

The following was sent to an Atlanta doctor with a specimen of urine in a half-pint flask for examination:

My morning "extract" here I send,
'Tis what you wanted, I suppose,
I hope and trust 'twill not offend,
Or make you elevate your nose.

No cocktail sweet, no toddy long,
This festive vessel doth contain,
And though it is not very strong,
I'm sure that it would stand a strain.

Although 'tis pleasant to the sight,
I send it with an anxious sigh,
And hope that no disease of Bright
Will meet your penetrating eye.

Dear Doctor, note the amber gleam,
But do not be deceived by this,
Things are not always what they seem,
This half-pint flask is full of——!

—*Southern Medical Record.*

Western Medical Reporter.
A Monthly Epitome of Medical Progress.

.. XV. DECEMBER, 1893. No. 12.

Original Articles.

bscess of the Liver. Operation; Recovery.

By G. Frank Lydston, M. D., Chicago, Illinois.

fessor of the Surgical Diseases of the Genitourinary Organs and Syphilology in the Chicago College of Physicians and Surgeons. Attending Surgeon Cook County Hospital, etc.

While abscess of the liver is by no means a frent disease in temperate climates, it occurs with icient frequency to lack the element of novelty, were it not for the fact that an early diagnosis followed by operation and leading to the recovery of the patient is rather exceptional. The history of the case which I am about to relate is interesting in many respects. The patient, a strong, athletic man of 53 years of age, first consulted me on the 20th day of May. I had known the gentleman for ten or twelve years, during which time I had never attended him professionally, and he had never been to my knowledge seriously sick. His history for many years had been that of a healthy man, with one exception, which was, that during a violent fit of coughing in the course of an attack of so-called bilious fever and pneumonia, thirty years ago, during the civil war, he had apparently wrenched himself in the epigastrium. Since that time he claimed that he had been conscious at times of a feeling of weight and soreness in the epigastrium, and from time to time he had suffered from attacks of what had been pronounced gastralgia. These were coincidental with dietetic and alcoholic excesses. He had not been a hard drinker, but would come under the class of so-called temperate drinkers, and his indulgences were usually associated with excesses in eating. These attacks would pass away in a few days. At times they would last but a few hours, and were never followed by jaundice, constipation, fever, or any general symptoms of any kind whatever. About the 13th of May, 1893, he suffered from one of his old attacks, which was rather more severe than any he had previously experienced. The pain was spasmodic in character, very acute, but subsided in about an hour under the administration of morphia. I did not see him in this attack, nor have I ever seen the patient or prescribed for him during similar attacks. After the attack of pain just described, he was apparently in his usual health, but his wife had noticed that he tired easily and complained of fatigue on coming home in the evening from his daily occupation.

On the 19th of May he began to feel quite ill. As he described it to me, he was "sick and achey all over." He had a slight chill; he also developed considerable cough, which was of a short, hacking character, almost incessant, and attended with considerable pain in the right side and in the epigastrium, pain in the epigastrium being especially marked. On the 20th he consulted me at my office. He still suffered from cough, pain in the right hypochondrium and epigastrium, with severe exacerbations on coughing; still complained of feeling very much prostrated; pains in his bones and muscles. He presented an expression of distress, and in general looked like a very sick man. His temperature was 102.5°; pulse 110; there was tenderness over the liver; some tenderness over the entire abdomen. The epigastrium seemed to be the focal point of tenderness; the bowels were constipated. Examination revealed a slight bronchitis. He endeavored to repress his hacking cough on account of the pain in the right hypochondrium and epigastrium. I gave him at this time a mercurial cathartic and a capsule containing 3 grains of phenacetine, 5 grains of salol, and 2 of quinine, to be repeated every three hours. I instructed the patient not to return to his place of business, but to go home and go to bed, and if he were not feeling better in the morning to send for me. I was not sent for until the afternoon of May 21st. At this time the pain was still marked in the epigastrium; cough quite annoying; there was an obscure sense of fullness in the epigastrium which he referred to his "stomach." He insisted that this fullness was due to something that was lodged in his stomach, the removal of which would cure him immediately. He stated that he had the same sense of oppression in the epigastrium that he had for a good many years. The temperature was now 103.5°; pulse 120; there was considerable meteorism. On the evening of the 21st the temperature was 103°; pulse 108. No antipyretics had been given at this time. On May 22d meteorism increased; morning temperature 102.4°; pulse 120; evening temperature 104°; pulse 130; very moderate use of antipyretics; the symptoms otherwise the same as on the previous day with the exception of the increase in the meteorism.

May 23d. Morning temperature 103.5°; pulse 120; evening temperature 102°; pulse 118; stopped the antipyretics. The tongue was now dry and brown; the tongue, lips and teeth were covered with sordes: a decided inclination to somnolency; pain in the hypochrondrium and epigastric pain not so marked; cough less prominent; still some tenderness in the epigastrium.

May 24. Morning temperature 100°; pulse 110; evening temperature 101°; pulse 120; somnolency increased.

On May 25th, A. M., temperature was 101°; pulse 114, very intermittent and irregular. Evening temperature 101°; pulse 114; cough somewhat better. Some cerebral excitement. Ice bags were applied to the sides of the neck and to the cranium; no antipyretics were administered. The pulse was so alarming that digitalis was administered. Icterus was now noticed for the first time.

May 26th and 27th. Temperature, 99.4°; pulse 108 to 120, and showing the beneficial effect of the digitalis. Pain and tenderness over the hepatic region improved; cough still better, but more or less painful; drowsiness has increased, and the patient has become more or less incoherent.

Until May 24th I considered that I had to deal with a case of typhoid. The early appearance of sordes, the dryness and dark color of the tongue, the peculiar character of the pulse and a sudden diminution in temperature without antipyretics, taken in connection with the localized pain and tenderness over the liver, now led me to suspect the existence

either of a primary hepatitis or possibly some hepatic complication modifying the course of an otherwise typical typhoid. At this time I informed the patient's friends that I suspected an acute abscess of the liver, either as a complication or the essential condition present, and suggested that Dr. William E. Quine be called in consultation. My advice as to counsel was followed, and Dr. Quine and myself accordingly met, and after a thorough canvass of the situation we concluded that a positive diagnosis was at that time impracticable, and arranged for a further consultation 48 hours later.

On the evening of the 25th, after careful exploration of the patient's abdomen, I was confident that I could detect a circumscribed induration in the epigastrium, extending down to within an inch and a half of the umbilicus. There was a dullness on percussion, and I thought that a reasonably clear outline of the involved area of resistance could be determined by palpation. To me the diagnosis seemed now reasonably clear in spite of the apyrexia, the temperature being at this time slightly subnormal. On the evening of the 26th, as a preliminary to the coming consultation, I took my instruments to the patient's house prepared to do a laparotomy should I receive the support of counsel. At the request of the family Dr. Sheldon Leavitt was added to the force of consultants. The final consultation occurred on the morning of the 27th, at which time I expressed my opinion that we had to deal with a circumscribed tumor in the left lobe of the liver with a possible abscess diverticulum of a secondary nature in the right lobe. My consultants agreed as to the probability of pus in the liver, but held that it was in all probability in the form of disseminated abscesses. Counsel agreed to my proposition to use the aspirator. I accordingly aspirated; first over the right lobe, and passing the needle upward and slightly inward toward the median line in the direction of the diaphragm beneath the free border of the rib, pus was struck at the first aspiration. I then aspirated in what appeared to me to be a ciscumscribed area of induration in the epigastrium, and after several dry taps withdrew a syringe barrelful of what was seemingly seropurulent material. Much to my discomfiture the eminent gentlemen associated with me in the case asserted that I had aspirated the stomach. As a result of the consultation laparotomy was counseled against. I, however, was not perfectly satisfied, and left my instruments at the patient's house. As my consultants had carried the fluid away for examination, I had no immediate prospect of microscopical study of the fluid, but impressed by the urgency of the case, and moreover as my microscope was at my office several miles away, I determined to aspirate again, and during the afternoon of the 27th I called at the patient's house and after the administration of a glass of whiskey and water, colored with several grains of cochineal, I again aspirated in the epigastrium. The appearance, and a subsequent microscopical examination in company with my friend, Prof. Hektœn, of the fluid which I withdrew, convinced me of the correctness of my conclusions in regard to the case. Accordingly on the morning of the 28th, I called Dr. J. B. Murphy to assist me at the operation, and performed a laparotomy, making a free incision over the area of induration in the epigastrium.

The operation was done under ether anæsthesia with the usual aseptic precautions. On cutting down the median line, and exposing the peritoneum, I found, much to my gratification, that adhesions had occurred between the visceral and parietal peritoneum, thus enabling me to do an extraperitoneal operation. A large aspirating needle was plunged into the prominent left lobe of the liver which presented at the opening, and on withdrawing the piston the barrel of the syringe was rapidly filled with seropurulent fluid. The Paquelin thermocautery was now pushed into the liver tissue in the direction of the point of the needle, with the result of evacuating a large quantity of pus. The opening was now enlarged with the finger, the abscess cavity thoroughly explored, and it was found to have involved practically the entire extent of the liver and to present a diverticulum running off into the right lobe. The pus in this diverticulum was much thicker, and presented more of the characters of ordinary pus than from the left lobe, which was comparatively thin. I will state for the benefit of those who may suspect that the gall bladder was opened, that it was at no time exposed during the operation, nor had I any reason to believe that it communicated with the cavity of the abscess. As an illustration of the depth and extent of the abscess cavity, I will state that a pair of Kocher forceps could be passed both to the right and left of the median line clear to the handles without meeting any obstruction.

The cavity was packed with a liberal quantity of iodoform gauze, and the usual dressing applied. On the second day after the operation, temperature was slightly subnormal, the pulse 118, and of excellent vitality; patient still somnolent, and aroused with difficulty. Icterus still perceptible, although not marked. Third day after the operation, an enormous quantity of bile began to pour from the abdominal wound and saturated the dressings; bile continued to flow from the wound in large quantities for two weeks, when it gradually began to subside, and in a few days had practically disappeared from the discharge. There was a free purulent secretion, but no attempt at repair in the open laparotomy wound for practically three weeks, when it began to heal, and at the end of seven weeks it was perfectly closed. The temperature following the operation fluctuated between the normal and a degree subnormal until toward the close of the case, when it assumed a normal standard and remained normal thereafter.

The tongue, lips and teeth continued to be covered with sordes, which reformed as fast as it was removed for four weeks after the operation. The tongue was dry and brown constantly during this time. At the end of about four weeks it began to clear up coincidently with the administration of dilute nitrohydrochloric acid. For several weeks the patient continued somnolent, and was with difficulty aroused. At the end of three weeks somnolency began to alternate with apparent attacks of mania and insomnia. At times the patient was quite violent, and was with difficulty controlled. For about three weeks after his somnolency began to disappear, his mental condition was very bad, so much so that I suspected some latent cerebral trouble, which had developed under the influence of the constitutional disturbance and toxic disturbance of the brain incidental to hepatic disease. At the end of three weeks, during which time he remained in practically the same condition from day to day, I concluded to experiment a

little, and administered Hammond's *cerebrin* in doses of five drops, three times daily. I mention this rather apologetically, and not with the intention of making any claims for the cerebrin. Whether as a coincidence or not, however, within forty-eight hours the patient began to improve, and went on improving steadily thereafter until convalescence was completely established at the end of the eighth week after laparotomy. It would by no means be surprising if the cerebrin so-called were responsible for the improvement. I imagine that nitroglycerine in small doses would have had a similar effect. Whatever the physiological effect the cerebrin may have—and any one who like myself has tried it upon himself must acknowledge that it has a physiological effect—is undoubtedly due, in my opinion, to the presence of nitroglycerine; whether as an accidental or intentional ingredient, is of no moment. I will state that about two weeks after the first operation, I explored the liver in all directions on two occasions with aspirating needles of large size with a view of searching for possible purulent collections still remaining in the liver. Dr. D. R. Brower, who saw the case in consultation with me about two weeks after the operation, was inclined to believe that the patient's mental condition was dependent upon pus pockets still remaining in the liver, or upon iodoform poisoning. Thorough aspirations failed to detect pus, and the cessation of the iodoform dressing produced no appreciable effect.

The points of most practical interest in this case are, it seems to me, (1) the probable causation of the abscess by an attack of hepatic cholic. (2) The rapidity of formation of pus in the liver. (3) Its location. (4) The early period at which the diagnosis was established. (5) The extensive and speedy destruction of the hepatic tissue. (6) The pronounced and prolonged disturbance of the mental faculties incidental to the toxæmia resulting from hepatic disease. (7) The afebrile course of the case after pus had undoubtedly formed. (8) And most striking of all, the recovery of so old a patient with so serious an envolvement and destruction of hepatic tissue.

It is possible that my patient is not through with his troubles, and I have in mind the possibility of the necessity of a cholectotomy and removal of gall stones later on. At the present time, however, his digestion is perfect; he has an excellent appetite, and is regaining his health as rapidly as one could reasonably expect. A few days since I sent him upon a trip to Mackinaw with the hope of a more speedy restoration to health. It is hardly necessary to call attention to the fact that the favorable result in this case was entirely dependent upon the early diagnosis and operation. Every practical surgeon knows the high mortality attendant upon hepatic abscess, whether operated on or not. My case is an excellent illustration of the rapidity with which the hepatic tissue will break down under the mechanical and toxic influence of pus infection, and shows plainly why, in cases which are not early discovered, surgical measures, however skillful, so frequently fail to relieve the patient. How frequently the diagnosis of hepatic abscess is made only upon the post-mortem table every practicing physician and surgeon is only too painfully aware.

Notwithstanding the disagreement between Dr. Quine and myself as regards the desirability of surgical interference, I can but express my deep obligation to him for the valuable assistance which he gave me in counsel. Our difference of opinion was after all, not upon the question of a suppurative process in the liver, but of its circumspection and consequent amenability to surgical interference. Frequent daily examinations and careful observation of the case for some days gave me a manifest advantage, which the surgeon does not always have in cases which are primarily of an essential medical character.

I have not attempted to present the literature of hepatic abscess nor to enter into an elaboration of the foregoing case; either would detract from the practicality of the report, and would certainly add nothing to its clinical value.

Carbolic Acid Used in Full Strength in Surgery.*

By Oscar H. Allis, M. D., Surgeon to the Presbyterian Hospital.

*Read at the Meeting of the Philadelphia Academy of Surgery, October 2, 1893.

Surgeons in early days of antiseptic surgery attributed their success to carbolic acid. As introduced, it was employed in a dilute aqueous or oleaginous solution. For a time it was the sole antiseptic. To-day it is mainly used in general surgery as a bath for surgical instruments. Few surgeons will demand a reason for its abandonment. Few have not personally experienced its benumbing effects, and have thus been able to assign the collapse following its employment to something different than loss of blood, shock of operation or anæsthetic.

With such an experience of carbolic acid in its dilute form, I confess that I was quite astonished to learn from Dr. B. F. Gardner, of Bloomsburg, that he was in the habit of using the article in its full strength upon extensive cut surfaces, and that, too, with the happiest results. As this article owes its entire value to Dr. Gardner, I will give in detail his method.

When Lister introduced his paste Dr. Gardner used it quite extensively. After an application to quite an extensive wound surface he was surprised to find it turn white, and that he had used pure carbolic acid. He therefore immediately washed the surface and dressed the wound, keeping it open until oozing had ceased. The case did so well that it inaugurated with him a line of treatment that he has extensively employed. As a typical application let me take an amputation of the female breast. After its removal and the ligation of the bleeding vessels, carbolic acid crystals, dissolved in sufficient water for solution, are applied with a sponge to all parts of the cut surface. Immediately upon the application of the acid the tissues turn white, which is a guarantee of its thorough action. The wound surface is then washed with water previously sterilized by boiling, and then approximated with provisions for drainage. This is especially necessary, as for twenty-four hours the oozing must find ready exit. During the first few days there is a slight local hyperemia along the borders of approximation, but this declines without crisis.

Dr. Gardner claims for carbolic acid applied in officinal strength:

1. That no systemic absorption attends its use, and hence no danger, no shock.

2. That it is a local anæsthetic. Hence there is not as much pain after the operation.

3. That it is in a measure a hæmostatic, acting especially upon the capillary vessels.

I have taken the removal of the mamma only as an illustrative case. In all operations outside of the pleuritic and abdominal cavities, such as amputations and resections, Dr. Gardner resorts to it.

In hydrocele he lays open the sac freely, then applies carbolic acid to the tunica vaginalis, and concludes with packing or drainage. The operation is not followed by excess of any kind, and recovery is prompt. He has used it in gunshot wounds of the knee and ankle. If he gets such a case after suppuration has set in he freely opens the joint, applies the carbolic acid to every part, washes out all excess freely, secures ample drainage with fixation, and confidently awaits the result. Anchylosis may follow, but this will depend on the extent of the injury, the delay in treatment, the conduct of the patient. Dr. Gardner has used bichloride of mercury, hydrogen peroxide, iodoform, etc.; none of them has answered the claims made for them; all have disappointed him, but pure carbolic acid *never*.

I have said that Dr. Gardner does not use this upon serous membranes, *i. e.*, within the abdomen. I must modify this statement. In a case of strangulated hernia, in which he found patches of sphacelus, not deep, but threatening, he cautiously applied the pure acid and returned the gut. Fortunately, the strangulation had been arrested by operation in time to save the gut. Nothing eventful in the subsequent history, which was speedy.

I do not know Dr. Gardner's theory of the actions of this powerful drug, and shall attempt no explanations. The turning of the wound surface white is due probably to the coagulation of the albumin of the tissues and fluids of the wound surface, and not that the acid has a necrotic effect. That it does not produce a true destruction of tissue may be inferred that after a large breast or thigh amputation he will have primary union and no suppuration. In its use in hydrocele a half drachm or more is injected into the tunica vaginalis, and resolution without suppuration ensues. It is possible that by its action upon the wound surface an action similar to that obtained by heat may be produced, and thus facilitate repair.

I will conclude this article by briefly stating my own experience with it.

On entering the wards of the Presbyterian Hospital I found that one of my amputations of the thigh had not done well, and looking at the stump found it swollen and of an angry, threatening character. The seam of approximation was perfect. I therefore removed all the sutures, and separating the flaps found them almost in a stage of gangrene. Taking carbolic acid pure, I applied it freely, pressing it into the tissues with the sponge applicator, removed the excess, and packing the space between the flaps renewed the dressing. This was done without anæsthetic and without apparent pain. The exposed surfaces soon began to granulate, when they were approximated, and recovery soon followed. I have also frequently applied it upon a carrier with cotton to sinuses and after curetting glands.

Discussion of Dr. Allis' Paper.

Philadelphia Academy of Surgery, Meeting October 2, 1893.

The President, Dr. William Hunt in the Chair.

Dr. H. R. Wharton: I would like to ask if Dr. Allis has seen carbolic acid poisoning from the use of the agent in this way. I have never seen much trouble from the use of carbolic acid except in children. At the Children's Hospital I have seen two or three cases where its use has produced a marked constitutional effect. In one instance where a large nævus was dressed with carbolic acid application there was a dark-colored urine and other symptoms of poisoning.

Dr. William J. Taylor: I think the application of pure carbolic acid to a fresh, clean surface, such as is left after the removal of the breast, is totally unnecessary. If you have a thoroughly clean skin, clean instruments, ligatures, and hands, you will have primary union. If such a fresh surface is smeared with carbolic acid there will be a large amount of oozing. My experience with a few cases where strong carbolic acid solutions were used a number of years ago, was that healing was much retarded.

As an application to suppurating surfaces such as Dr. Allis speaks of, and where you wish a cauterizing and disinfecting action, I consider carbolic acid one of the best agents that we have, and use it frequently.

Dr. W. Joseph Hearn: If carbolic acid is applied to a raw surface otherwise healthy, one would expect to have a certain amount of necrosis of the tissues. Some cells will be destroyed, and afford a soil for the propagation of germs.

Dr. Richard H. Harte: Dr. Leivs was in the habit of using carbolic acid for its cautery effect. I remember several cases where he used it freely, producing large sloughs over the posterior surface of the thigh.

Dr. Allis: In regard to poisoning, Dr. Gardner claims immunity from poisoning from the fact that the application sears the whole surface and closes the small vessels, and nothing is taken into the system. Dilute solutions are rapidly taken up. In one case where I operated on two herniæ in the same individual, there was a good deal of collapse following the use of a dilute solution of carbolic acid.

I am not prepared to say whether it has a necrotic action or not. I do not understand how Dr. Gardner gets primary union using it as he does if it has such an action.

I think that Dr. Gardner probably began its use with the idea that there might be left after amputation of the breast some cells which it would destroy. I do not bring this forward thinking that any one will be led to use it in these cases, but there is a big lesson in this use of carbolic acid. There are places where it is valuable, for instance, in deep sinuses and pus tracts. I have injected it into a psoas abscess, so that it would run out—probably eight ounces—without the slightest constitutional effect.

I can subscribe to what Dr. Harte says. Care must be taken that the carbolic acid does not come in contact with the skin. If it touches the skin it will blister it, but when applied to a raw surface it does not have the effect which we should expect. In a few cases where it has been injected into the tunica vaginalis the patients have almost died, but in a large majority of cases carbolic acid pure in hydrocele effects a happy cure, and without suppuration. Hence without necrotic action.

In collecting some cases of accidents in the treatment of hydrocele, such cases were reported to me.

As to whether or not the application in recent surgery is necessary or advantageous, I leave that for individual opinion. I have seen bichloride solution do as much mischief as carbolic acid probably could do in preventing primary union.

Dr. L. W. STEINBACH: In speaking of the use of carbolic acid, Dr. Levis has been referred to. A number of years ago I had the pleasure of assisting Dr. Levis in the removal of an ovarian cyst, in private practice. At that time the spray was used. The assistant who had charge of the spray put the carbolic acid in the bottle and the water on top of it without mixing the two, so that a spray of pure carbolic acid was delivered into the wound and on to the operator's hands. The doctor's hands became so benumbed that he was unable to introduce the stitches. The woman, however, made an excellent recovery.

Of course, every one knows the good success of Dr. Levis in the treatment of hydrocele with carbolic acid. He was careful that none got into the connective tissue or on the scrotum. I never saw an accident in any of his numerous cases.

Report of Three Months' Service in the Jefferson College Hospital.

BY W. JOSEPH HEARN, M. D.

Read at the meeting of the Philadelphia Academy of Surgery, October 2, 1892.

The object of this report is not to include every minor operation, which number over one hundred, but only those which may prove of interest.

One case of fæcal fistula. A young woman, married, two weeks after her first confinement, sufferedfrom a strangulated femoral hernia. Her physicians claimed to have reduced the hernia under ether. Subsequently an abcess formed at the femoral ring, was opened, with escape of gas, pus, and some fæcal matter. Four months after she presented herself at the hospital, suffering from an almost constant escape of gas and fæcal matter from a small tortuous sinue below Poupart's ligament. By means of a very small flexible bougie, I was enabled to find the way into ths bowel. I cut down on this bougie, following up the sinus until the bowel was reached. As I could feel no spur, I concluded that there was simply a small opening in the bowel. I freshened the edges and closed the wound. Twenty-four hours after symptoms of obstruction of the bowel occurred, with peritonitis, followed by death in three days. A post-mortem examination revealed that, instead of perforation of the bowel with a small opening, a large section of the bowel had been caught in the ring, and at least two-thirds of the circumference had been lost in the slough. The lesson taught me in this case and in other similar cases that I have seen, that the abdomen should be opened in the middle line or outside of the linea alba, in addition to dissecting down through the sinus, in order to find the condition of the bowel and the amount of lost tissue. This was a case for lateral anastomosis.

A second case of abdominal section has the following history:

A woman sixty-three years old was admitted to the ward, suffering with obstruction of the bowels of three weeks' duration. The abdomen was enormously distended, and fæcal vomiting. Incision was made in the middle line, below the umbilicus. The intestines were so much distended that it was impossible to locate the seat of obstruction. An incision was made into the small intestines and their contents milked out. This procedure necessarily caused much fæcal matter to be spilled in the abdominal cavity. After reducing the contents of the abdomen, the obstruction was easily located. It was a carcinomatous contraction of the middle portion of the transverse colon, with extensive adhesions to the surrounding parts. As it was found impossible to remove the section of bowel involved, an artificial anus was made in the right side. The colon just above the ileo-cæcal valve was attached to the abdominal wall and, as the symptoms were urgent, immediately opened. The peritoneum was so tender and brittle, due to inflammatory infiltration, that it was with great difficulty that sutures could be made to hold. The same difficulty was encountered when I attempted to close the opening made in the small intestines. The parts were so thickened that it was almost impossible to invert the intestinal walls for the Lembert sutures. The intestines were returned with great difficulty into the abdominal cavity, which was then thoroughly irrigated. The patient rallied from the shock promptly. Her temperature did not go beyond 101° F. She improved daily, and left the house in four weeks almost as well as she was before the obstruction occurred. The carcinoma had given her but little trouble before the obstruction, not sufficient to cause her to call for medical advice.

A third abdominal section was for ligation of the external iliac atery for an aneurism involving the femoral under and beyond Poupart's ligament and a large portion of the external iliac in the abdominal cavity. The patient was a male, aged forty, and in good health. I determined to do the trans-peritoneal operation. The artery was tied without much difficulty by placing the patient in the Trendelenburg chair and packing the bowels away from the point that I wished to place the ligature, with large pads of antiseptic gauze. The patient made a good recovery, and left the hospital cured. As I shall report this case more fully in another paper, I have purposely omitted much of the technique of this operation. I had two years previously ligated the femoral artery of the same limb.

Two Cases of Amputation of the Penis for Epithelial Cancer.—In one case the glands in the left groin were involved, which were removed with much difficulty. The left limb was very œdematous, due to pressure of the enlarged gland on the veins. The difficulty of removal was due to the proximity of those glands to the veins. The patient made a satisfactory recovery.

Five cases of hydrocele were operated upon by the open method. That is, the sacs were incised for about one inch; the edges of the sac caught with hæmostic forceps to prevent difficulty in getting into the proper cavity. After the cavity is thoroughly dried with antiseptic gauze, pure deliquesced carbolic acid was applied to every part of the serous membrane. Then an iodoform gauze drainage was inserted and left for forty-eight hours. Should the incision be larger than necessary a few catgut sutures can readily be introduced, to partly close the opening. The drainage which this mode of procedure admits of insures absolute success. Anæsthetics are not necessary, as the line of incision can be frozen with chloride of ethyl, and the application of the acid or any other

caustic causes no more pain than when injected. Those cases, where the sac is very thick and cannot collapse, or where covered with calcareous plates, are not adapted for this mode of treatment. Only entire or partial excision of the sac will cure that class of cases. The operation of laying open the sac and attaching it to the scrotum, and then packing, I never perform on account of the subsequent deformity.

Three Cases of Varicocele with Elongated Scrotum.—I have ceased to perform the operation by the subcutaneous method. Both of these cases were operated upon by the open method, and a section (one inch) of the veins removed. The tied ends are then sutured together with catgut, which insures the shortening of the scrotum. Catgut is also used for ligatures of the veins. The most satisfactory way to reach the veins is to transfix the tissues with knife or scissors, each side being lifted with forceps as the gynæcologist approaches the peritoneum. It can be done rapidly and without danger of wounding the vein. With proper antiseptic precautions and properly sterilized catgut the patient will make a more rapid recovery than with the subcutaneous method. I never use drainage, but close the serous membranes with catgut and the skin with silk.

One Amputation of the Forearm for Epithelioma of the Wrist, which Almost Encircled the Arm.—For two years this patient had submitted to the application of caustics from a cancer-curer until the pain became unbearable. The wound healed by first intention, not a drop of pus having been seen. But the pain in the arm never ceased. A multiple neurosis followed the local one after the patient left the hospital, and the patient died eight weeks after the amputation. Alcoholism could not be ascribed as a cause. Was it the continued use of the caustic applications, which several times caused sloughs, so the patient informed me, that caused exposure of the bones and the tissues between the bones?

Four Cases of Amputation of the Thigh; one for Sarcoma Springing from the Periosteum of the Thigh Bone about the Junction of the Upper with the Middle Third.—The tumor measured twenty-eight inches in circumference, and approached the joint so far that an amputation of the hip was thought proper. Wyeth's pins were inserted and the rubber band applied. The flaps were cut for hip amputation, but when the bone was reached it was found in such good condition that the head was not removed. The patient made an excellent recovery and gained much flesh. She was seventy years old and much broken in health when admitted to the hospital. The second case of amputation was for a chronic syphilitic endostitis and necrosis of the lower end of the femur, with an old synovitis of the knee joint, in a man forty-five years of age, and in an almost exhausted condition. The amputation was made at the junction of the upper and middle third of the thigh. The marrow was soft, almost fluid, and entirely disorganized, and it was not deemed proper to leave it. As the bone seemed healthy I curetted up as far ar the trochanter major, and packed with iodoform gauze. The patient suffered very much from shock during and after the operation, but from that time on he improved daily without a single untoward symptom until entire recovery. The third case was that of a man aged thirty-three years, admitted to the hospital suffering from acute gangrene of the left leg. His history was that three weeks previous he had a second attack of an apparent appendicitis under the care of my friend, W. L. Coplin. The pain, however soon subsided in the right iliac region, but severe pain was felt down the left leg. The pain was excruciating, and could scarcely be controlled by large doses of anodyne. Soon after the pain began it was noticed the discoloration of a linear character occurred. It followed the course of the superficial nerves, and apparently involved only the skin. Soon gangrene of the entire limb occurred, with great depression of the nervous system. A line of demarcation formed above the knee, and an amputation was advised. The limb was removed at about the middle third of the thigh. The operation was followed by great shock. Very little blood was lost. He rallied for a few days, when gangrene commenced in the right limb. At the same time it was noticed that there was no perceptible pulsation in the left radial artery. He sank slowly and died at the end of ten days from an extensive gangrene of the right leg. His previous history was not good. He suffered from chronic alcoholism. He did not suffer from disease of the valves of the heart, but from a fatty heart. An embolus was the apparent cause of the gangrene. The fourth case was that of a boy aged twelve years, who previous to this illness never was sick. April 1 he commenced having pain in the left knee, and was treated for rheumatism. Soon the swelling involved the knee-joint as well as the whole leg below. His case was then supposed to be one of acute cellulitis, although there was no history of injury or any previous abrasions. He was admitted to the hospital, and several openings were made in the leg and large quantities of pus evacuated. His temperature fell for a few days, but soon arose to 103,° and the boy was slightly delirious. Then it was found that the joint itself was involved. It was opened, and a large quantity of puro-sanguinolent fluid escaped. Still the temperature continued above normal, and the boy was still delirious. Other pockets of pus were looked for and opened. Bedsores were threatened, and his condition grew worse. At the third operation it was discovered that the boy suffered from epiphysitis of the tibia. Necrosis at the epiphysis had occurred. As the knee-joint was disorganized, and the leg from the ankle to the knee was one mass of suppuration, an amputation was advised and accepted. He bore the amputation well, and almost from that day his delirium ceased. The wound healed promptly without suppuration. Very little is said of epiphysitis in the text-books. I think this disease occurs more frequently than we are aware of, though suppuration and necrosis are very rare. I have the history of three other cases, though the symptoms were of a much milder type than the case just mentioned.

One Case of Floating Cartilage of the Knee-Joint.—This I will exhibit to you, and I think you will agree with me that it is one of the largest. Its dimensions are 1½x¾ inches.

The man, aged forty-five years, suffered for many years with what he supposed to be rheumatism in his left knee. It had never impeded his locomotion very much. For a long time it must have been too large to impinge itself between the tibia and femur. Its position was on the left lateral aspect of the knee-joint. I cut freely down on it and removed it without difficulty, as it was not attached to any of the fimbriæ of the Synovial membrane. Considerable sy-

novial fluid escaped. The synovial membrane was closed with catguts sutures and the skin as usual. No drainage was used. He made a good recovery without anchylosis.

One Case of Neurectomy of the Infraorbital Nerve in a Lady of Seventy-three Years, who had Suffered Many Years from Neuralgia.—Three years previously I had removed the inferior dental nerve for her, with relief for two years. I removed the entire nerve by a trephin opening at the angle of the jaw to the mental foramen. After two years the pain returned in the infraorbital nerves. This was removed by making a V-shaped notch in the lower border of the orbital bone down the foramen. By that means I am sure to secure the nerve with all its filaments. Then lifting up the eyeball with a retractor and breaking through the thin floor of the orbit, I was enabled to break off the nerve as far back as its origin. Very little deformity follows the removal of the wedge-shaped bone. It is now five months since the operation and there has not been any return of pain.

One Case of Amputation of the Tongue.—Male, aged seventy-three years. He suffered for many years with papilloma of the tongue, shown in small white plaques. These were partly removed by transfixing with fine needles and tied off. When admitted to the hospital about one-third of the tongue was infiltrated. It was twice its normal thickness, very hard and painful. The glands at the angle of the jaw were also involved. The tongue was transfixed near its tip, and a strong ligature drawn through to give control of it. The patient was placed in a Trendelenburg chair, and the head so depressed that no blood could enter the trachea. After etherizing, chloroform was used during the operation. Those who have not used the Trendelenburg chair for operations about the face, nose and fauces, can scarce appreciate its usefulness in preventing suffocation from blood entering the trachea. It prevents the many interruptions to the operator on account of that accident. It does away with the necessity for tracheotomy. With the tongue elevated and pulled strongly forward, it controls hæmorrhage, as suggested by Heath. Then, with a pair of scissors or a knife, the mucous membrane is divided in a smooth, even, curvalinear line at the junction of the tongue with the floor of the mouth. The object of this line is for the subsequent attachment of the upper portion of the tongue to it. After the tongue was freed as far back as necessary, ablation was commenced. With a pair of scissors the tongue was divided by a series of snips until one of the lingual arteries was reached, when it was quickly caught and tied. The pulling forward of the tongue so controlled hæmorrhage that but a few drops of blood escaped. Before the next artery is reached another ligature is drawn through the stump, that it, too, may be under control when the tongue is divided. The stump is then brought forward and sutured to the mucous membrane of the floor of the mouth. By this method there is very little surface exposed for absorption of septic material, and the prevention of septic pneumonia greatly enhanced. This patient was fed with a tube attached to the nozzle of the feeding cup, and by that means the food was placed far back in the fauces, and did not come in contact with the wound. The enlarged glands were removed, exposing the large vessels of the neck. The patient made a rapid recovery. The stump and floor of the mouth united rapidly, and in six days all the sutures were removed. He suffered much from shock after the operation, but soon rallied. About half of his tongue was removed.

One Case of Resection of Knee-joint in a Female aged Twenty Years.—Had suffered for ten years from traumatic synovitis. Her general health good. No history of tuberculosis. When the joint was opened an inflammatory erosion of the entire joint surface was found. The ends of both tibia and femur were sawed off. Temporary fixation of the bone was made with catgut sutures and a plaster splint applied. Recovery satisfactory. She left the hospital in eight weeks with good union. Had her to continue to wear a light splint for a few weeks longer.

Four Amputations of the Mammary Gland for Scirrhus.—In each case the axilla was opened and all its contents removed. Fat was removed regardless of the fact that in two cases no enlarged glands could be felt. Yet in both cases, when the axilla was opened, minute glands could be distinguished in the fatty material removed. I operate on all cases of carcinoma of the mammæ where the disease has not so far advanced that its removal is impossible. This rule applies to chronic or fibroid scirrhus as well as to the acute variety. I feel it is more beneficent to the patient to let her die of internal cancer than to die of exhaustion due to local ulceration, with all its physical and mental distress. However much confidence the patient may have in her family doctor, who advises her not to have it touched with the surgeon's knife, sooner or later she will disobey his instructions and consult a surgeon, or else fall into the hands of the cancer doctor, with his escharotics. Which of us causes the greatest physical suffering?

Five Cases of Hare-lip.—One of the cases simple. Three of the cases with cleft palate, both hard and soft, and one case with double cleft, with intermaxillary bone projecting. In this case I removed the intermaxillary bone, believing, with Rose, that it interferes with the proper approximation of the lateral maxillary bones. The teeth that form in it are never perfect and are ever useless. I do not use hare-lip pins in approximating the parts, but use silkworm-gut, both at the vermilion border and at the cutaneous surface. I use either catgut or silk sutures for the intervening parts and the mucous membrane. The advantage of the silkworm-gut over pins is that it can be left in longer without cutting or sloughing and supports the parts equally as well. I never operate on a child under one month of age. There is no necessity for it, and union is much less certain.

Four Cases of Suprapubic Cystotomy.—One case of chronic cystitis of ten years' duration, with a small phosphatic calculus. One case of a foreign body in the bladder, part of a soft catheter, and two cases of stone in the bladder. The specimens I now exhibit. The largest stone is from a male patient aged sixty-one years. Occupation, bookkeeper. He suffered for six years with all the symptoms of stone, but his sedentary habits made it endurable until a few months before he was admitted to the hospital. The stone weighs five ounces and is $7\frac{3}{4}$ inches in its greatest circumference. It is smooth, and to that fact is probably due his long tolerance of it. It is probably a uric acid calculus with a phosphatic crust. I was formerly prejudiced in favor of a lateral lithotomy, as I had always operated by that method. Now I am convinced that in adults the proper treatment is either supra-pubic cystotomy or lithotripsy, the

choice of treatment depending upon the size of the stone or the condition of the bladder and kidneys. I have never crushed a stone in a young child, yet I think it the proper treatment.

DISCUSSION OF DR. HEARN'S PAPER.

Dr. O. H. ALLIS: I would ask Dr. Hearn if he has seen any sloughing in the case of hydrocele, where he has used carbolic acid?

Dr. WILLIAM J. TAYLOR: I had the pleasure of seeing Dr. Hearn operate in the case of intestinal obstruction referred to. I never had seen such distension of the intestine. The small intestines were larger than the average colon, and the tissues were so soft that the sutures wore out. It is simply a miracle that the woman survived.

Dr. W. W. KEEN: It is impossible to refer in detail to the five series of cases which Dr. Hearn has reported from a service of eight or ten weeks, but there are two points to which I should like to call attention. One is the use of the Trendelenburg posture in all cases of operation about the mouth and nose. A preliminary tracheotomy has often been advised and has been done in these cases. Of course, tracheotomy is not one of the most serious operations, but it does add to the complications. As Dr. Hearn has said, I believe that the use of this position will practically do away with preliminary tracheotomy in most cases, and always if the tracheotomy be for the purpose of preventing blood entering the larynx and lungs.

I notice, also, with much pleasure, that Dr. Hearn has drawn attention to the importance of uniting the mucous membrane after removal of the tongue. I think that this is of great importance, in order to avoid as far as possible any opportunity for septic infection. In removal of the lower jaw in a number of cases I have endeavored to unite the mucous membrane so as to cover in the raw surface entirely. If we do that there is no opportunity for infection of the system.

These two points in the surgery of the mouth are of great importance, and it is only in late years that I have recognized their importance; but experience has taught me the immense benefit to be derived from these procedures.

Dr. HEARN: In reply to Dr. Allis I would state that I have never seen sloughing from the use of pure carbolic acid. In one case, where the surgeon introduced a dilute solution, sloughing followed, and a few days later the testicle could be seen. Where I have used pure carbolic acid I have never seen any accident. I have always injected it until I began this procedure of opening the sac. I have never seen the latter operation fail. The opening permits thorough drainage, and is sure to succeed.

ITEMS.

The Homœopathic Examining Board of New York State has rejected fifty per cent of the applicants who have appeared before it.

TOBACCO ODORS ON THE BREATH.—To remove the smell of tobacco from the mouth or breath, Grahame (*Apotheker-Zeitung*) advises bromo-chloral, a few drops in a glass of water, with which the mouth is to be well rinsed.—*Medical Age.*

THE originator of the intense creasote treatment for tuberculosis, Prof. Sommerbrodt, died at his home in Breslau, August 14, 1893.—*Lancet-Clinic.*

NITRATE OF SILVER STAINS are easily removed by painting the part with tincture of iodine and then washing in dilute aqua ammonia.—*Pacific Med. Jour.*

Dr. Leslie E. Keeley has dismissed his libel suit against the *London Lancet*, alleging that his American engagements would prevent his presence in England at the trial (?)

A MODIFIED CANNON-BALL TREATMENT OF OBESITY.—Dr. Felkin, of Edinburgh, uses an India rubber ball, three and one-half inches in diameter, almost filled with five and three quarter pounds of shot, in the treatment of chronic constipation, anæmia and obesity. The patients are instructed to roll the ball from right to left round the abdomen five or ten minutes night and morning. One of his patients had lost ten inches in girth after five months regular use of it. A rather smaller ball with a less quantity of shot he finds very useful in inducing a regular action of the bowels in young girls, who so frequently suffer from habitual constipation; this plan obviated the need for constant dosing.—*Ex.*

GELSEMIUM AND GELSEMINE IN RHEUMATISM AND NEURALGIA.—Doctor A. Atkinson says: There is no question but that Gelsemium will afford relief in many cases of neuralgia, but it must be pushed far enough to secure its physiological effects (just short of injury) if it is expected to obtain full relief.

In facial neuralgia it has been found that twenty minims of the tincture, or three minims of the Normal Liquid, administered every half-hour for three doses, almost invariably relieves.

Gelsemine is safe to administer when the alkaloid can be readily procured, is of known purity, and has not been kept too long. When employed in tablet form, Doctor Atkinson suggests as a good plan to stick a hole in it, and let the patient swallow in half-softened state.

LISTER'S RENEWED ALLEGIANCE TO CARBOLIC ACID.—It is not surprising to those who have kept pace with the progress of antiseptics to hear Sir John Lester, after twenty years' of investigation and experiment, declare his renewed allegiance to carbolic acid, as he did in a lecture January, 1893, at Kings College Hospital in London (*Annals of Surgery*, June, 1893).

Carbolic acid is not only a more efficient surgical germicide than corrosive sublimate, but it is much more efficient in cleansing the skin. It has a powerful affinity for the epidermis, penetrating deeply into its substances and it mingles with fatty materials in any proportion. Corrosive sublimate on the other hand cannot penetrate in the slightest degree into anything greasy; whence those who use it require elaborate precautions in the way of cleansing the skin. All of this is unnecessary with carbolic lotion. Sir Joseph does not even use soap and water trusting entirely to the carbolic acid.

There is a new product of phenol and boracic acid, in which has been mitigated the pungency of carbolic acid, disguising its odor, and greatly supplemented its efficiency by its combination with boracid acid, which, although admittedly slower in its action, is nevertheless, unsurpassed as a true germicide.—*Pacif. Med. Record.*

Western Medical Reporter.

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JOHN E. HARPER, A. M., M. D., EDITOR.

G. FRANK LYDSTON, M. D., HUGH BLAKE WILLIAMS, M. D., } ASSOCIATE EDITORS.

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THE EDITOR would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the full name and address of the writer, although not necessarily to be published. All communications should be addressed to

WESTERN MEDICAL REPORTER, 1101 Masonic Temple, Chicago.

Dr. F. Byron Robinson.

Dr. F. Byron Robinson, of Chicago, graduated from Wisconsin University as B. S. in 1878. He then resumed his occupation as principal of schools. In 1882 he graduated from Rush Medical College and began practice at Grand Rapids, Wisconsin. In 1884 he went to Europe to study gynæcology, and pursued his studies in Heidelberg, Berlin and London for a year and a half. In 1887 he again went to Europe, studying a year at Venice. In 1889 he was offered and accepted the chair of anatomy and clinical surgery in Toledo Medical College, where he removed and remained two years. He then went to England to be a pupil of Mr. Lawson Tait for six months. On his return he removed to Chicago where he was appointed professor in gynæcology in the Post Graduate School. Dr. Rohinson has pursued original investigations and experimental surgery of the pelvis and abdomen for the past six years. He has experimented on the pelvic organs and intestioes of over 200 dogs. He wrote two volumes of "Practical Intestinal Surgery." He originated several new intestinal operations, and invented three plates for intestinal anatomosis, namely the Cartilage plate, the Raw Hisk plate, and the Segmented Rubber plate. These plates have proved successful in the human. Dr. Robinson's whole time is devoted to gynæcology, abdominal surgery and original investigations.

DR. F. BYRON ROBINSON.

He is a frequent contributor to current medical literature. Some of his more important articles are: "Automatic Menstrual Ganglia," "Abdominal Brain," "Peritoneum," "Pathology of the Fallopian Tube," "A New Operation to avoid removing Myoma," and investigations on the comparative anatomy, physiology and funclions of the genitals of animals and man. Dr. Robinson has earned his own money and worked his own way since he was 17 years old, when he left the old farm. He says his father's encouragement to get an education was his first and greatest stimulant. His father, who still resides on the old homestead in Wisconsin, is a wide general reader, and used to read to his family. Dr. Robinson is a member of many medical societies, local, state and national, and an honorary member of several.

The Great Value of a Close Observation of Other Men's Work.

The paper on this subject read by Dr. W. H. Link, of Petersburg, Ind., at the meeting of the Mississippi Valley Medical Association contains as many truths as could well be crowded into the space. Hero worship comports in with the spirit of modern medicine and the *ipal dixit* of no man is to be regarded as the sum of knowledge on a given subject. The spirit of inquiry and investigation is too strong to allow of any sitting with folded hands unless they elect to be among the stragglers of medicine's army.

Dr. Link has observed Would there were more like him. He says, "By observation and contact the country doctor and general practitioner soon learns that the Professor's chair docs not always hold either a great teacher, or a great operator, and that in the case of some who write our books the pen is mightier than the scalpel. This fact makes some observation a prime necessity to him who would essay the intricate and trying work that pertains to the higher and more important surgery.

The text-book written from the library of a bungler who holds down a chair in some powerful medical school is foisted upon the readers of the profession as a guide. The old store of cuts that have done service since the time of Astly Cooper or John Hunter are resurrected by wealthy publishers; and lurid advertisements, liberally paid for, induce the masses to buy. By just such means as this we are lead to fill our libraries with a lot of trash which we find blind guides in emergencies and false teachers in the common every day practice that comes to us all. A very small amount of observation of these men in their work will soon teach us that books are often written as a personal advertisement and floated upon the market by the same means that put the authors into a surgical chair or gave them a hospital appointment.

Close observation will likewise show that medical colleges and medical professorships no longer dominate the profession as in days gone by. They are more in the nature of kindergartens, where the infantile medical mind is shown the rounded globes of therapeutic systems, the perfect squares of surgical doctrine.

By observation one soon learns that as authorities teaching the newest and the best, teaching it ably and thoroughly, post-graduate schools now occupy the position that a few years back was held by medical colleges.

By seeing work done under varying conditions and with different results we readily come to the conclusion that a private hospital is by no means necessary to successful work. That the pure air of a country or village home, or a clean room in a private residence in the city, is as good a place for surgical work as the most painted and gilded hospital, and that no one need hesitate because his patient cannot have the supposed advantage of some place specially set apart for the sick.

But, while recognizing and appreciating the great value of observation, we cannot forget that in its absence there is always room for genius to surprise by its own creations; and we remember with pride that the two greatest men in modern surgery, McDowell and Sims, were a product of the backwoods, and that their triumphs were worked out far from the maddening crowd.

ABSTRACTS.

Medicine.

BRAIN BRUISES.—Sir William Savage, in a recent number of the *Lancet*, claims that bruises of the brain are not uncommon after injuries to the head. In addition to the existence of concussion of the brain-matter, there may be gross lesions. These injuries vary very much in extent from a mere pinkish coloration to rupture of the vessels and the formation of blood-clots. As it is quite impossible to say that the brain-matter has not been lacerated, in the case of concussion, the prognosis should always be given guardedly. The author also thinks that if there is marked drowsiness, headache, loss of consciousness, marked loss of mental power, and difficulty in rousing the patient's attention, there is good reason to suspect brain bruises or lacerations.—*Alienist and Neurol.*

TREATMENT OF MEASLES BY EUCALYPTUS INUNCTION.—Dr. C. A. Shelley, in the *Practitioner*, reports the results of this application in five cases.

The patients occupied a ward of five beds, and were in no way selected cases. Inunction was begun directly they came under observation, the oleusaban being rubbed over the body night and morning for three days, and subsequently once a day for the first week. The eucalyptus emulsion was given internally, some of the fluid was placed in saucers about the room, and when cough was troublesome eucalyptus inhalations were given.

The immediate effect of the treatment appeared to be to produce great drowsiness; all five patients slept almost constantly, being roused with some difficulty to take their food, and remaining awake only just long enough to consume it. There was very little coughing in this ward for the first three days; the patients were not markedly thirsty, and they complained of but little discomfort of any kind.

Three patients had considerable (muco-purulent) conjunctivitis, and all five had tongues thickly coated with white fur, thus contrasting markedly with the tongues of others under different treatment.

In one case the rash was coming out when treatment commenced; but in the other four its appearance seemed to be delayed, the temperature remaining at from 102° F. to 104° F. for four or five days before the appearance of the eruption on the face and body. When it did appear, the rash was very copious, much raised, and of a notably dusky tint.

During the fourth, fifth, and sixth days four of the patients developed laryngeal and bronchial catarrh, with complete loss of voice in two cases; and one developed a severe attack of pneumonia affecting both basis in patches (the only case in the whole epidemic of pneumonia occurring as a direct complication).

Convalescence was in all five cases more tardy than usual, and desquamation much more profuse. In the case of the patient in whom the rash was coming out when treatment commenced, peeling was not very marked; but in the other four cases, face, hands, legs, and feet desquamated freely and for a lengthy period. In one case in particular, at the end of six weeks the desquamation of the palms might readily have been mistaken for that of scarlet fever.

DIAGNOSIS OF EPILEPSY BY THE URINE.—Dr. Gilles de la Tourrette claims that a diagnosis between hysterical epilepsy and that due to neoplasm can be made by the examination of the urine. He has found that there is an increase in the elimination of urea and phosphates during a convulsion due to a tumor, while the amounts excreted during an attack of hysterical epilepsy are diminished.—*Med. and Surg. Rep.*

DIAGNOSIS OF INEBRIETY FROM APOPLEXY.—Dr. Mills, in a recent clinical lecture on the case of a man picked up in the street unconscious, remarked as follows:

"This man has no external evidence of fracture, but sometimes without fracture or with concealed fracture, a sudden fall or blow on the head will produce an extradural or subdural hæmorrhage. Such patients are usually unconscious at first, and often regain or partially regain their senses and again relapse into unconsciousness. One dilated pupil, convulsions, and some hemiparesis, are among the prominent symptoms of such a lesion. The signs and symptoms present do not point clearly to this lesion.

"Other diagnosis to be considered are those of drunkenness, opium poisoning, epilepsy, uræmia and embolism or cerebral hæmorrhages, perhaps still others, but these are the most important.

"Profound alcoholic intoxication can be excluded, as this patient is evidently absolutely unconscious, and suffering from profound paralysis, more marked on one side than on the other. In dead drunkenness, while consciousness may appear to be lost, the condition is rather one of extreme stupor or stupidity, and the patient, by strong excitants, can usually be made to respond in way, although he may immediately sink again into his stuporous state. The smell of liquor on the breath may help, but this cannot be relied upon, as a patient insensible from any cause may have been drinking. Both sides of the body are equally affected in extreme alcoholic intoxication.

"Several facts will easily exclude opium poisoning, such as the sudden onset, the absence of pinpoint pupils which will not dilate, and the peculiarities of the state of insensibility. As the man was seen at the time of and immediately after his attack, and for other reasons, the post paroxysmal sopor of epilepsy can be dismissed.—*Journal of Inebriety.—Med. and Surg. Reporter.*

THE MECHANISM OF SYNCOPE FROM CHLOROFORM.—M. Laborde thinks (*Le Progrès Médicale*), besides the reflex irritation of the pituitary and the irritation of the superior laryngeal nerve, might, in some cases, have other very important influence.

M. A. Guérin, however, felt obliged to consider that practically it is the irritation of the pituitary which acts the most important part in causing syncope. For this reason chloroform should not be inhaled except through the mouth.—*Sanitarian.*

BRIGHT'S DISEASE AMONG THE INSANE.—In the biennial report of the Alabama Insane Hospital, *Alienist Neurologist* it is stated that forty-four consecutive autopsies have been made within the past year and a half. In seventy per cent of these cases the kidneys were abnormal. Dr. Bondurant, acting superintendent, says that albumen and casts have been detected in the urine of more than one-half of the 1,300 insane patients subjected to examination and that some form of Bright's disease is recognized in at least half the patients admitted to the asylum. In 702 patients examined Dr. Wright formed valvular heart lesions in 11.72 per cent.

THE ACTION OF BICARBONATE OF SODA ON THE FORMATION OF CHYME IN THE STOMACH was the subject of a report to the Société de Biologie, at its session July 22d, by M. Gilbert. The report (*Le Progrès Médicale*) gave the results of experiments which he had pursued for more than a year on the same animal. The dog had a gastric fistula, and the soda, mingled with any kind of food desired, could be introduced and its action studied with such dose as desired and at a time convenient for its administration. In large doses it retarded gastric action; in small doses it excited action if given half an hour before meals.—*Sanitarian.*

CHANGES IN THE URINE IN MYXŒDEMA AFTER THYROID EXTRACT TREATMENT.—Ord and White present the following preliminary conclusions from a study of one such case:

1. The urine is increased in volume.
2. Nitrogen excreted in the urine exceeds the total nitrogen of the food.
3. Phosphoric acid and chlorine elimination are unaffected.
4. The increased nitrogenous excretion is chiefly in the form of urea.
5. The body weight is diminished.
6. The temperature of the body is raised.—*Brit. Med. Journ.—Am. Med.-Surg. Bulletin.*

RAPID DETECTION OF CHOLERA BACILLI.—In the *Zeitschrift für Hygiene* and the *Zeitschrift für Analytische Chemie* Professor R. Koch describes a suitable method for detecting even single cholera microbes in drinking and river water. While observing the well-known precautions, a small quantity of the suspected water is added to a solution of peptone and allowed to stand at a temperature of 37° C. If only very few cholera bacilli capable of development are present they increase very remarkably at the above temperature in from six to twelve hours. Owing to their avidity for oxygen they collect upon the surface of the liquid, where, under certain circumstances, they form a fine, though distinctly visible, film. When a drop of the liquid from the surface is examined microscopially the characteristic "common bacilli" are to be seen in prodigious numbers. In order to be quite certain in the diagnosis, a drop is taken from the surface of the liquid and made up with gelatin (or preferably agar plates)according to the old method. If the gelatin plates are allowed to remain at a temperature of 22° C. (or the agar plates at 37° C), in from ten to fifteen hours the cholera bacilli, if present, will have grown to characteristic colonies, so that in the most difficult case a demonstration can be secured in from twenty-one to twenty-seven hours. The occurrence of processes like the above should tend to emphasize the importance of bacteriological examination as a useful, and in some cases a necessary, addition to chemical analysis.—*Lancet.*

CAN LIVING CHOLERA BACILLI BE CARRIED WITH DUST THROUGH THE AIR?—Thin layers of finely powdered garden earth, fine white sand, street and floor sweepings, and mixtures of dust and diarrhœal discharges, were moistened with cultures of cholera bacilli. They dried in fourteen to sixteen hours, and were then pulverized. At various intervals of time cultures from these mixtures were obtained by inoculation and by allowing the dust disturbed by being blown upon to settle on gelatine planes. The results of all the experiments were the same. While the bacilli died rapidly during the process of drying, some of them were still alive after the lapse of twenty to twenty-four hours, if sunlight were excluded, were carried about with the dust, and developed colonies. As an exception solitary bacilli survived three days. The lesson is clear. Although the slight liability of the materials soiled by chloreaic discharges to the formation of dust, and the rapid death of the bacilli in drying substances (materially hastened by the action of sunlight), render the propagation of cholera in this mode exceptional, it is, nevertheless, possible for living cholera bacilli to be carried with dust through the air, and to infect food, water of streams, etc., or to enter our mouths.—*Berliner klin Wochens. —Med. and Surg. Rep.*

AN ORGANIZATION OF COLORED EROTOPATHS.—Apropos of my paper on "Erotopathia," I am credibly informed that there is, in the city of Washington, D. C., an annual convocation of negro men called the drag dance, which is an orgie of lascivious debauchery beyond pen power of description. I am likewise informed that a similar organization was lately suppressed by the police of New York City.

In this sable performance of sexual perversion all of these men are lasciviously dressed in womanly attire, short sleeves, low-necked dresses and the usual ball-room decorations and ornaments of women, feathered and ribboned head-dresses, garters, frills, flowers, ruffles, etc., and deport themselves as women. Standing or seated on a pedestal, but accessible to all the rest, is the naked queen (a male), whose phallic member decorated with a ribbon, is subject to the gaze and osculations in turn, of all the members of this lecherous gang of sexual perverters and phallic fornicators.

Among those who annually assemble in this strange libidinous display are cooks, barbers, waiters and other employees of Washington families, some even higher in the social scale—some being employed as subordinates in the government departments.—*Dr. Hughes, in Alienist and Neurol.*

ACUTE PARENCHYMATOUS NEPHRITIS.—Dr. Aufrecht (*La Semaine Médicale*, No. 61, 1893), treats acute parenchymatous nephritis as follows: As soon as albumen and casts are found in the urine the patient is placed in bed, where he is to remain until the albuminuria disappears. Institute at once a regimen in which the nitrogenous substances are reduced to a minimum. The patient is allowed bread, biscuits, coffee, sweetened with but little milk, gruels made from barley or oat grits, or other farinaceous substances, mashed potatoes, with butter, and prune preserves, etc. As a drink give him water charged with carbonic acid, to which raspberry syrup or red wine is added. This treatment will suffice as long as there is no considerable diminution in the twenty-four hours' quantity of urine. As soon as anuria sets in he does not combat it with diuretics which are not efficacious and even injurious, but by administration of an alkaline water, the quantity of which will vary according to the age of the patient. This increases quite considerably the amount of urine secreted. The anuria being due to an obstruction of the renal canaliculi by casts, diuretics are inactive, and an alkaline water favors their elimination and restores the permeability of the renal filter.—*Lancet-Clinic.*

MANAGEMENT OF CONVALESCENCE OF TYPHOID FEVER.—In an article in the Charlotte *Medical Journal*, Dr. W. E. Fitch says:

I never allow solid food until the temperature has been normal for at least eight or ten days. I think this is a safe rule, leaning toward extreme caution; then I allow eggs, milk toast, milk puddings, jellies, etc. Many leading practitioners allow solid food as soon as patient desires it, but I had a *lesson* in this matter while I was a student in City Hospital, Baltimore. A man about twenty-eight years old was convalescing very nicely. I was quite interested in this case. Two weeks after his temperature had been normal, and a few days before his intended discharge, he ate several mutton chops, and within twenty-four hours was in a state of collapse and died from perforation. I assisted Dr. W. G. Keirle, pathologist, with the autopsy, and found a small transverse perforation at the bottom of an ulcer, which was in the process of healing. Since this I have been very chary about solid foods at the beginning of convalescence. It was quite a lesson to me.

Constipation is quite common during convalescence, and is best treated by enemata. Among the danger of convalescence may be mentioned tuberculosis, which, as Murchison says, is more common after typhoid fever than any other fever.

A MEANS OF RELIEF IN HAY FEVER.—The capriciousness of hay fever, and the occasional relief obtained from an entirely empirical method of treatment warrant the publication of any means which has proved successful, in the hope that it may be of use to some other person afflicted with this annoying and disabling disease.

Ferber, of Hamburg, reports his own case, which had been so severe as to necessitate his using a closed carriage all through the summer. His relief was brought about from accidentally noticing that in the winter a coryza was usually accompanied with hot ears which regained their normal temperature when the discharge from the nose was established. He determined to try a reversed order of effect on the hay fever in the summer, and began accordingly to rub his ears until they became red and hot.

It is now the third year that he has been able to lead an endurable existence during the hay fever season. "As soon as the least sensation of fullness in the nose appears, there is recognized a certain amount of pallor in the ears. A thorough rubbing of the ears, at times even to contusion, has always succeeded in freeing the nasal mucous membrane from its congestion. The rubbing, however, must be *thorough* and repeated as often as the least symptom of congestion returns to the nose. Since using this means I have been able to take long sandy walks, sit and even sleep with open windows or pass the evening in my garden without distress. Several patients have had the same relief from this treatment, always in proportion to the thoroughness of the rubbing, and I hope by this means some other physician may be able to give his patients the same great relief.—*Boston Medical and Surgical Journal.*

Surgery.

SUPPURATION IN CEREBRAL VENTRICLES.—In the *Birmingham Medical Review* Mr. Berlyn reports a case under the care of Mr. Barling—that, namely, of a child three and a half years of age who was admitted on account of frontal headache. The child had had a discharge from its right ear since it was six months old, and fourteen days before admission it had fallen on some bricks and injured the right side of its head. On admission there was found to be retraction of the head without paralysis or strabismus, and the temperature was 101.6° F. There was no optic neuritis. During the next week the child was very irritable, vomiting frequently, and the temperature remained about normal. There was tenderness over the right mastoid, and operation was thought to be justifiable. The bone was chiseled away, but no cavity existed; the right lateral sinus was freely exposed and was found to be healthy. The wound remained quite aseptic, but the child became more drowsy, there was a discharge of pus from the left ear, and it sank rapidly. At the necropsy the pial surface of the brain was found to be much injected, and on section a large quantity of pus was present in both lateral ventricles, which had also penetrated the Sylvian aqueduct and distended the fourth ventricle. The sinuses were normal except that they contained some secondary clot; the dura mater and bone over the tympana were normal, and the other organs revealed no focus of inflammation or other abnormal appearance.—*Lancet.*

EXTIRPATION OF THE WOUNDED SPLEEN.—Riegner (*Berliner Klinische Wochenschrift*,) reports the following interesting case: A boy, fourteen years old, fell from a high scaffolding, striking upon the abdomen. When seen the patient was extremely pale, and was vomiting a brownish fluid. The abdomen was markedly distended and very tender, and there was retention of urine. Rupture of one of the large abdominal viscera being suspected, laparotomy was performed, notwithstanding the shocked condition of the patient. The spleen, which was found completely torn through, was removed after ligation of the vessels. Two subcutaneous injections of 300 grammes of a 0.6 per cent solution of sodium chloride were

administered. Twelve days after the operation the satures were removed. Several weeks later it was found necessary to amputate the left thigh for gangrene, but despite these two severe operations the patient recovered. At the present time there is a general enlargement of the external lymphatic glands, and also enlargement of the mesenteric glands. It would, therefore, appear as if the lymphatics had assumed the function of the spleen. The relation of the white to red corpuscles was at first 1:100; the absolute number of the red corpuscles rapidly increased up to normal; that of the white corpuscles did not decrease.—*Univ. Med. Mag.*

Depressed Fracture of Skull; Comatose one Week; Totally Blind Four Weeks; Trephined; Recovered.—The following rare and interesting case occurred in my service during August and September:

Willie Stricker, æt. eight years, German parentage, was brought in on the afternoon of August 23, suffering from a comminuted fracture of the vault of the skull, received by being tossed by an engine against the side of the Erie tunnel. He was collapsed, cold and nearly pulseless. Remained in this condition for three or four days; barely able to swallow; perfectly unconscious. After one week had improved a little and it was then found that he was perfectly blind. Operation for elevation of depressed bone done two weeks after admission and four pieces removed aggregating the size of a silver dollar. Upper posterior angle of left parietal one inch to left of sagittal suture and involving some of the occipital (both sides of occipito-parietal suture). Dura mater not injured or lacerated. Decided improvement followed in two or three days, and in ten days he was out of bed and feeling his way about the room. Sight was restored quite suddenly about three weeks after operation.

At no time was there any paralysis of motion or sensation observed, the only objective symptoms being those of extreme concussion and loss of vision.—*Sampson in Arch. of Pediat.*

The Treatment of Thirst After Abdominal Operations.—Thirst, as is well known, is often a source of great trouble to patients who have had some abdominal operation performed upon them. It is commonly the case for fluids by the mouth to be withheld from the patients for some days before the operation is performed, partly in order to minimize the risks of chloroform sickness, and partly to avoid exciting peristalsis of the intestines. Thus there is no difficulty in comprehending how thirst is induced in these cases. The question, however, arises, in what manner can it be most readily dealt with? The usual custom has been to give ice to the patient, but not much relief from the pressing symptoms is obtained by this plan. The best method, however, appears to be the administration of warm water enemata, repeated at stated intervals. Absorption from the rectum takes place so rapidly that fluids reach the circulation by means of enemata almost as quickly as when the direct injection of fluids is made into the veins. The quantity injected into the rectum should not exceed a pint at a time, and the fluid used should be pure water slightly warmed. The relief obtained soonbecomes manifest.—*Medical Press and Circular.*—*Lancet-Clinic.*

Pudic Nerve Neurectomy for Masturbation.—Dr. J. S. Eastman (*Med. News*), of Berkley, Cal., relates the case of a woman aged twenty-six years, who for twenty years had been a confirmed masturbator in spite of all kinds of treatment. She had the drugs, blistering, and cauterizing of the genitals, wire sutures in the labia, clitoridectomy and ovariectomy, all without avail. He then cut out three inches of the left pudic nerve, and for a year and one-half now she has had no return of the habit, has gained thirty-three pounds, has become happy and sociable. He considers her cured. This cannot be settled until the systemic effect of the operation has passed off. Then masturbation often recurs. Hence the effect is mentally constitutional and not surgical.—*Lancet-Clinic.*

Removal of Superfluous Hairs.—In a paper read before the recent meeting of the American Dermatological Society, by Dr. R. B. Morrison, of Baltimore, Md., the author stated that he has given up the use of electrolysis in the removal of superfluous hairs. The results which he had had himself, and those which he had seen of others, have not been sufficiently good to warrant its continuance. He finds that the proper application of a good depilatory answers the purpose much better. There are many women who wish to get rid of the white lanugo down on their faces, upon whom it seems that electricity cannot be used for fear of stimulating the growth of the surrounding hair, and the appearance of permanent scars. If a preparation of yellow sulphate of arsenic and quicklime, of equal parts, made into a paste with hot water, be allowed to dry on the hairy skin, it removes the hair for ten to twenty days, and sometimes permanently. On the other hand, nothing seems to take the place of electrolysis where there are a few strong hairs growing from moles, in the removal of moles themselves, in angioma, or in permanent small, red spots.—*Medical Summary.*

Paralysis of the Arm Following the Application of an Esmarch's Bandage.—Dr. James Bell related at a recent meeting of the Montreal Medico-Chirurgical Society, the history of the case, the circumstances being, in his experience, unique. A young woman, twenty years old, admitted to the hospital January 16, with ankylosed elbow joint. The position was not a very bad one, being a little greater than a right angle. The history of the injury was as follows: On the 6th of last July she fell in a car, and, knocking against the wall, hurt her elbow. At the time she did not pay much attention to it; but after awhile, the joint having become stiff, it was thought necessary to call on a doctor. The latter attempted passive motion, which was partially successful, but the ultimate result was ankylosis in the above position. Excision of the joint was advised, to which she after awhile consented, and the operation was carried out in the ordinary way. It was noticed, after removal from the operating room, that she had no power in any of the fingers, and that even sensation was not normal. Owing to the hand being encased in dressing, no very accurate observation could be made for some days, but it was remarked that the fingers perspired profusely. At the end of the third day after operation, being anxious and unable to explain the paralysis (the operation was done subperiosteal, and he was sure no injury had been done the ul-

nar nerve, besides, injury to the latter would not account for paralysis of all the fingers and muscles of the forearm), the dressing was removed, and the explanation was at once patent. The Esmarch had been applied in the upper portion of the arm, just above the belly of the biceps, and below the prominence of the deltoid, and it had been tied so tightly that the skin was blistered. There was consequently no longer any doubt as to the Esmarch being the cause. The whole operation only occupied forty minutes, so that the band altogether could not have been applied more than half an hour. Upon the discovery of the neuritis she was at once put under the care of Dr. Stewart. Motor paralysis remained absolute for three weeks. On the twenty-first day, the first sign of movement returned, being a slight motion of the thumb; and after about six weeks' treatment she returned to her home with almost complete power of the arm. Once movement began to appear, it progressed very rapidly. She was able to flex and extend the arm and fingers completely, though not with the full amount of power. There, however, was no motion deficient.—*Med. and Surg. Rep.*

SENILE GANGRENE.—In the Virginia *Medical Monthly*, November, 1893, Dr. G. W. H. Kemper reports a case of this affection, from the study of which he makes the following conclusions:

1. While the gangrene is confined to one or two toes, it is best to defer amputation. If the disease extends to the dorsum of the foot, amputation is proper.

2. Amputation below the knee is rarely successful, owing to lack of proper blood supply and tendency to recurrence of gangrene in the stump.

3. Amputation through the thigh will save a large per cent of the cases, and especially so when the subjects are free from a general disease. Mansell-Moullin observes that usually the thigh is small and wasted in the lower third; the artery is sound in Hunter's canal; the flaps are well supplied with blood; and old people, as a rule, resent operation very slightly; their tissues are not prone to inflammation.

4. When amputation has been performed below the knee, and gangrene appears in the stump, unless the patient is greatly exhausted it will be proper to perform a secondary amputation above the knee.

Therapeutics.

PHOSPHATE OF COPPER IN TUBERCULAR TUMORS.—Dr. St. Germain, the well-known children's surgeon, uses two injections of copper in white tumors (*Am. Ther.*). The first contains: 'Crystallized phosphate of soda, five grammes, with distilled water and glycerine, of each thirty grammes. The second: Acetate of copper, one gramme, to twenty each of water and glycerine. These are mixed without filtering. They must be well shaken before using. As a rule, they are injected behind the great trochanter only once in two weeks. It is not very painful and shows its action by fever, which will run up to 38° or 38.5° C. (100° to 102° F.), and lasts three days. There is a local swelling of the ganglia, and some pain and stiffness. After the fever drops the whole general state improves, and the patient gets quite lively and gay, with an excellent appetite and general improvement. *St. Louis Medical Journal.*

AN EFFECTIVE DEPILATORY.—Butte (*Monatshefte für Practische Dermatologie*, 1893), recommends iodine collodium, which for three or four consecutive days is spread rather thickly upon the respective spots. When the collodium skin is removed the hairs will be found adhering to the under side.

Especially adapted is said to be iodine collodium of the following composition:

Alcohol	12.0
Iodine	0.75
Collodium	35.0
Oil Turpentine	1.5
Castor Oil	2.0

—*Medicin. Monatschrift.—Med. Age.*

BERBERINE SULPHATE IN LEUCÆMIA.—Vehsemeyer (*Therap. Monatsh.*, No. 4, 1893), reports a case of leucæmia in a child, aged nine months. He first administered the tincture of barberry, a few drops daily, and as this seemed to act favorably, the tincture was discontinued, and berberine sulphate, three parts in 3500 of alcohol, substituted. Of this solution five drops were given several times daily. In addition, the swollen glands were treated with an ointment containing in thirty parts, five parts of ammonium chloride and one part of camphor. Under the treatment the glands diminished in size, the grave symptoms completely disappeared, and the general condition showed marked improvement, when, unfortunately, death resulted from convulsions incident to teething.—*Annals of Gyn. and Pæd.*

RECTAL ADMINISTRATION OF PURGATIVES.—Dr. Kohlstock (*Norsk Magazin for Lægevidenskaben*), has experimented with four purgatives—aloin, cathartinic acid with senna, colocynth and citrulline. Subcutaneously given they produced violent pain; rectally they gave much better results. They were dissolved in proper vehicles and injected by means of a small syringe into the rectum. Aloin and cathartinic acid were found to be the best for slight and colocynth and citrulline for more obstinate cases of constipation. The following solutions were employed:

Aloin.....gm. 1 (grs. xv).
Glycerine.....gms. 10 (℥ijss).
Four to five grammes (1-1¼ drachms) in slight constipation.

Cathartinic acid with senna.....gms. 3 (grs. xlv).
Distilled water.....gms. 7 (℥ij).
Bicarbonate of soda to alkaline reaction.
Six grammes (1½ drachms) will have a certain action.

In obstinate constipation of long duration the following were used:

Colocynthine.....gm. 1 (grs. xv).
Alcohol, Glycerine } aa.....gms. 12 (℥iij).
Inject one-quarter to one gramme (15 drops).

Citrulline.....gms. 2 (grs. xxx).
Alcohol, Glycerine } aa.....gms. 40 (℥jss).
Inject one gramme (15 drops).

None of the remedies produced either irritation of the rectum or tenesmus, as is often the case with suppositories of glycerine. The evacuations were profuse, and the remedies used in this manner were followed by no tendency to constipation. After a long employment a slight accustomation is observed, but the dose must not necessarily be increased. No disagreeable side effects.—*Lancet Clinic.*

DUBOISINE.—E. Mendel recommends duboisine in paralysis agitans, not as a remedy but as a great palliative. After hypodermatic injection of two or three decimilligrammes of the drug, the tremor ceases for a period of three or four hours; sleep also is much improved thereby, and muscular rigidity increased. The remedy may be used safely for a long time, as there is no danger of formation of a drug habit.—*Neurolog. Centralblatt.—Med. Age.*

PICHI IN GENITO-URINARY DISEASES.—Friedländer prepared an extractfrom the plant fabiana imbricata, and found it to contain a resinous acid, tannin, and an alkaloid. Experiments on animals are not completed, but after proving its innocuousness, the author administered a teaspoonful of the extract three times daily to six patients suffering from affections such as cystitis, prostatitis, neuroses, acute ghonorrhœa, epididymitis, and balanitis, diseases for which it has hitherto been the practice to administer internal remedies. The general effect produced was good, sometimes to a surprising extent, and details of each case are given, showing especially its power in improving such conditions as frequent micturation, tenesmus with passage of blood and pus, pains in the lumbar region, etc. The extract, having a pleasant bitter though aromatic taste, increases the appetite, and for this reason alone is preferable to copaiba and sandalwood oil, while at the same time the remote action is at least equally satisfactory.—*Therapeutische Monatshefte.—Med. Age.*

COMPARATIVE INFLUENCE OF LARGE AND SMALL DOSES OF IRON.—The comparative effects of large and small doses of iron, and the indications for the one or the other are discussed in the *Therapeutic Gazette.* The experience of the writer in treating twelve cases of anæmia which were as far as possible alike, confirmed his belief in the value of small doses. Six of these people received two or three grains of reduced iron three times a day, and the remaining six received one-third of a grain three times daily. The six that received the small doses had far less disorder of digestion than those who received the large doses. They recovered as promptly as those receiving the large doses, if not more so. It is true that in some conditions in which there is gastrointestinal disorder associated with the formation of gas arising from fermentation or decomposition, and in which the anæmia is largely due to destruction of the constituents of the blood by the absorption of poisonous materials from the intestine, large doses of iron are absolutely necessary, because in these instances only a small quantity of iron is absorbed, and the greater amount of it forms a sulphide of iron, or other compound, with the contents of the intestine. Where we have, therefore, a destruction of the iron in large amount it may be necessary to give it in full dose; but unless this is the case one-eighth of a grain of reduced iron will, in most cases, give better results than three grains. Under these circumstances constipation more rarely occurs, and we also avoid in this way the so-called iron headache.—*St. L. Med. and Surg. Jour.*

PHYSIOLOGICAL ACTION OF OXYGEN.—In the *Lancet* Dr. J. L. Kerr writes:

In the month of November, 1892, I had in my possession a cylinder of compressed oxygen, in quantity about twenty cubic feet and of ninety-three per cent guaranteed purity. In a spirit of mere idleness a friend and I tried the effects of large inhalations of the pure gas; but quickly entering into the spirit of scientific accuracy we altered our methods and inhaled for a considerable period an atmosphere of nearly pure oxygen. We were both in perfect health and our observations, complete in our case, must not necessarily be supposed to be the same as in a state of disease. The results were most surprising to me; my friend had no medical knowledge and did not know what to expect and had, therefore, no preconceived opinions, and this gives more value to my report, as his experiences were the same as mine. Breathing the oxygen in a confined space, so as to inhale as little natural air as possible, and taking deep inspirations, I found that there was no flushing of the face or feeling of quickened vitality, as was shown by the absence of any exhilaration; there was no quickened pulse-rate and, as far as I could judge, there was not the slightest rise in temperature. These were the negative observations. The only positive result that we could see was a distinct diminution of the frequency of respiration. The intervals between the respiratory acts were greatly increased and there was a feeling that there was no urgency to repeat it; the *besoin de respirer* was entirely abolished for the time being. As far as I could judge the lengthening of the respiratory intervals balanced the increased supply of oxygen to the lungs, and therefore to the blood, in an automatic manner. I write this account of my experience of the inhalation of oxygen as my observations were confirmed at the meeting of the British Association at Nottingham. I was much struck with the facts at the time, and I only awaited confirmatory experience to publish my notes.

SALICYLATES IN THE TREATMENT OF PLEURAL EFFUSIONS.—Dr. George Dock (*Therap. Gaz.*) reviews this subject, and draws the following conclusions:

1. Salicylic acid and its salts are among the most effectual agents in the treatment of pleurisy with effusion.

2. In effective doses the remedy is harmless, and with proper care in the selection of the preparation and its administration, causes little or no discomfort to the patient.

3. Salicylates act most promptly in pleurisies with serous effusion of recent origin or of long standing, but they are efficient in simple dry pleurisy, and often act favorably in secondary pleurisy.

4. There is no evidence that they are useful in suppurative cases.

5. The drug acts as a diuretic, but may have an effect on the pathological process, or on the cause of the disease.

6. Salicylates have a more marked action on pleurisy than the diuretics commonly so-called.

7. The duration of treatment, with salicylate preparations, is less than with diuretics, common salt or roborant medication.

8. The remedy can be used at the earliest period, and favorably affects all symptoms.

9. The drug may be given in the form of the acid, or any of its salts, in doses of a drachm of the former, or one to two drachms of a salt daily. In ordinary cases it is not necessary to give the large doses; and sixty to ninety grains of sodium salicylate, or of salol,

may be considered full-beginning doses, to be diminished one-third or one-half, if the effect is manifest.

10. The ordinary precautions must be observed in giving the drugs, and during their administration the total amount of urine should be measured daily.—*Memphis Med. Monthly.*

Treatment of Aphthæ in the Œsophagus and Stomach.—Dr. Anfrecht, of Magdeburg (*Wiener med. Presse*, No. 39, 1893), states that while the disease in children is generally limited to the mouth, in adults, and especially in old and decrepit persons, it may extend down into the œsophagus and stomach and cause pain on swallowing, so that nutrition is greatly interferred with. In such cases he administers a three per cent solution of borax, one tablespoonful every hour or two, with good effects, for in one to two days the affection diminishes in intensity, and in a few days it entirely disappears. No disagreeable side or after effects were noticed after four or five days' use of the drug, or even if administered for a longer time if it be discontinued for a day or so.—*Lancet-Clinic.*

Calomel Soap in the Treatment of Syphilis.—In the *Lyon Médical* for October 29th there is an abstract of an article by De Watrazewski, credited to the *Revue des sciences médicales*, in which the author says that calomel soap, while it possesses all the advantages of the traditional gray ointment and the more modern gray soaps, is superior to them in the frictional treatment of syphilis, because it is free from the objections attaching to them. Its application is easy and takes little time. It is colorless and odorless, and neither soils the clothing nor irritates the skin. It is prepared by mixing the calomel in a state of vapor with a potash soap in the proportion of one to two, or one to three. The amount required for a daily friction is from thirty to forty-five grains, containing from seven to ten or fifteen grains of calomel. The friction itself is substantially the same as with ordinary mercurial ointment.—*N. Y. Med. Jour.*

External Applications of Guaiacol in Tuberculosis.—In a recent issue of the *Medical Week* Professor R. Lépine presents the following conclusions regarding the endermic application of pure guaiacol: 1. External applications of guaiacol are likely to prove extremely useful in certain cases of pyrexia of tubercular origin. 2. The application of from one to two cubic centimeter is practically devoid of all risk of collapse, provided the tubercular process has not reached the stage of suppuration and cavity formation. In the latter case two grammes may cause death, as in a patient under Dr. Bard's observation. 3. Except in cases of extreme irritability of the skin, the application of pure guaiacol is never followed by any inflammatory reaction. 4. The only disadvantages of this method in the earlier stages of pulmonary tuberculosis are profuse sweating, with or without shivering, and a few other symptoms of a very mild description, so that this remedy is to be preferred to antipyrine and even to acetanilide in many cases of phthisis, especially as it has no deleterious influence on digestion. Dr. Lépine agrees with Bard that guaiacol is absolutely without effect on patients suffering from hectic fever due to successive exacerbations of the pneumonic process or to the presence of suppurating ulcerations. On the other hand, it produces a powerful and lasting effect in cases of simple tubercular pyrexia, due to the formation of successive crops of granuloma; in short, whenever the fever is not due to septic infection superadded to the tubercular process. The influence of the guaiacol is largely to be referred to a reflex action on the nerve centers through the peripheral nerve endings, as experiments have demonstrated that the temperature is not affected in animals if the site of application is previously anæsthetized.—*New York Medical Journal.*

Balsam of Peru in Gastro-intestinal Diseases of Children.—Dr. Nuggia has contributed an article on this subject to the June number of the *Archivio italiano di pediatria*. It appears by a summary of the article given in the *Revue générale de clinique et de thérapeutique* for November 1st that Trousseau and Pidoux had recommended the remedy in gastro-intestinal catarrh, especially in diarrhœa, with or without tenesmus, in typhoid fever, and in infectious dysentery. The author uses the following mixture: From a grain and a half to three grains (for very young infants) or from five to seven grains (for older children) of balsam of Peru, forty-five grains of alcohol, half an ounce of syrup of lemon, and three ounces of water. He reports successful results from the use of this formula, and says that he has not observed any untoward action of the mixture; nevertheless, it is better not to prolong its administration more than three days, not on account of the balsam of Peru, but on account of the alcohol.—*N. Y. Med. Jour.*

Diseases of Women.

The Vomiting of Pregnancy.—At the last meeting of the London Obstetrical Society, Giles reported the analysis of three hundred cases of pregnancy in reference to the occurrence of vomiting. He found that only about one-third of pregnant women were free from vomiting throughout their pregnancy; that the sickness began in seventy per cent of cases in the first month, while in ten per cent, it began in the last three months. The sickness was least frequent in women between the ages of twenty and twenty-five, while adynamic phenomena, and usually remain free from hallucinations and other cerebral manifestations.

Dr. Holscher was enabled to dispense with the use of cold baths, and his typhoid fever patients never presented other than the mildest symptoms of the disease.—*Med. Review.*

The Reciprocal Effects of Pregnancy and Childbirth on the Operation for Shortening the Broad Ligament.—Alexander (*Annales de Gynecologie et d' Obstetrique*, vol. xxxix., 1893) says that many have accused the operation of Alexander of provoking abortions. In reality the author states that that the shortened round ligaments do not entirely support the uterus, but they maintain it in a normal position. Enlargement of the uterus during pregnancy does not produce lengthening of the round ligaments, but simply dilatation at the point of ligamentous attachment. Any lengthening that might take place is corrected during the post-puerperal period. The author reports seven cases operated upon by himself, all having become pregnant; the uterus did not return to the position for the relief of which the operation was required.—*Therapeutic Gazette.*

A Sign of Breech Presentation.—When in a woman who has passed the sixth month of pregnancy, a sharp pain is produced by placing the hand on the fundus uteri, it may be almost affirmed that there is a breech presentation. The fact is very frequent, although not constant, being present in about seventy per cent of cases. The pain is sometimes spontaneous. How is it to be explained? According to Pinard, it is due to the irregular distention produced by the rounded mass of the head. If version is performed, the pain disappears.—*La Clinique Internal.—Med. and Surg. Rep.*

The Mechanism of Labor; Some Experimental and Clinical Observations.—One. The chief factor in determining anterior rotation of the lowest portion of the presenting part is the resistance of the pelvic floor. .

Two. Complete forward rotation of the presenting part is the rule in primiparæ; it often fails in multiparæ.

Three. Excessive rotation of the head is a rare condition.

Four. A permanent occipito-position is more common in multiparæ than in primiparæ, other things being equal.

Five. Complete shoulder rotation occurs with about equal frequency in primiparæ and multiparæ.

Six. In primiparæ and spontaneous delivery the anterior and posterior shoulders appear with about equal frequency.

Seven. In multiparæ and spontaneous delivery the posterior shoulder appears first more frequently than the anterior.

Eight. In spontaneous delivery the posterior shoulder is born first more frequently in both primiparæ and multiparæ—three times as frequent as the anterior in primiparæ, two and a half times as frequent in multiparæ.

Nine. The posture of the parturient does not appear to affect the mechanism of shoulder delivery.

Ten. Manual extraction of the shoulders was found to increase the percentage of perineal lacerations.—*Edgar in Am. Jour. of Obstet.*

Ante-partum Decomposition of the Placenta, with Maternal Infection.—During the evening of December the 17th, 1891, I was asked to see Mrs. R, aged thirty-four. She informed me that she had had several severe chills, followed by fever, and was then suffering with headache and an aching over the body generally. She did not direct my attention to severe pain in any particular location; temperature, 104° F.; pulse rapid. I ascribed her condition to an attack of la grippe, which was then prevalent. About five o'clock the following morning I was again summoned, and found her recovering from a chill more severe than any previous. Her condition was altogether much worse, the temperature being 107.2° F.; pulse, 160. I then endeavored to ascertain some other cause for her condition. She had been married about six months, menstruation taking place regularly, and having no other symptoms of pregnancy, she did not think herself pregnant. On examining the abdomen I found the uterus enlarged and apparently gravid; therewas no vaginal discharge. The temperature did not remain high, but gradually lowered, so that in half an hour after, when Dr. A. F. McKenzie saw her with me it, was 105° F., and fell somewhat lower before we left her. Larger doses of sulphate of quinine than she had been having during the night were ordered. I saw her several times through the day, when she appeared to be improving. In the evening—that is, twenty-four hours after my first visit—I was again summoned, but being engaged, requested Dr. McKenzie to see her. On his arrival he learned that the fœtus had been expelled and destroyed, so that he did not see it. He however, removed the placenta, which was decomposed and very offensive; after irrigating the uterus, he left the patient comfortable. She ultimately made a good recovery.—*Cleland, in Dom. Med. Jour.*

Examination Under Anæsthesia.—In the *N. Y. Med. Jour.*, Dr. H. A. Kelly formulates his views as follows:

The Indications for the Examination under Anæsthesia.—1. In a young woman with an intact hymen.

2. When the ordinary vaginal examination is not satisfactory, leaving the question as to the condition of the appendages and the fundus uteri in doubt, provided—

3. That the patient's history and symptoms indicate an intrapelvic affection.

4. That the examination is made by a trained and gentle hand.

The fourth condition may be modified, however, in case of necessity, as any physician possessing a good general idea of pelvic diseases ought to be able to exclude the presence of serious intrapelvic lesions in the absence of resisting masses which are evident even to an untrained touch.

Nota Bene.—There should be no undue haste in proceeding to an examination under anæsthesia where the symptoms are not urgent. It is also often best to first test temporizing measures in cases which may be kept under observation.

The Limitations in the Employment of the Examination under Anæsthesia.—1. Unnecessary examinations must not be made. In the majority of cases an ordinary thorough vaginal examination, if conducted with a little tact and persistence, or, if necessary, a second examination at a later date, will afford sufficient information to direct the treatment.

2. Patients must never be examined without their full consent, and they must have the right to withdraw their consent at the last moment.

3. Great care must be taken in examining young girls. In no case should the hymen be ruptured except under stringent necessity. An index finger larger than six centimeters in circumference debars its possessor from the right to make a vaginal examination in young women even under anæsthesia. The preservation of this mark of her virginity is the sacred, inviolable right of every unmarried woman. The careless rupture of the hymen to secure information which can be as well or better gained by a rectal examination is an outrage. Even when it is necessary to dilate the cervix this can be done by catching the cervix with a forceps introduced into the vagina and guided by the rectal finger; in this way the uterus can be drawn down within reach, while the hymen is held gently open by a vaginal speculum.

4. No respectable unmarried woman should be used for class teaching. To place a virgin on the table under an anæsthetic at the disposal of a class of students is a defloration closely akin to rape, revolting to every honorable instinct.

5. Patients with tumors and pelvic inflammatory diseases should not be kept anæsthetized over half an hour, and never more than three physicians should be allowed to examine a patient under one anæsthesia.

6. These examinations must be made with great gentleness and under the direction of a responsible teacher, as rough examinations often rupture pus sacs, hæmatomata, and large cystic ovaries, or bruise the abdominal walls.

7. After such an examination the patient should rest for some hours, or even for several days in bed.

8. These examinations must be conducted in privacy, but few students being admitted to the room at a time.

9. Out of respect to the patient, visitors should not be permitted to come and go from the examining room during the examination.

How to Ascertain a Twin Pregnancy.—It is best done by abdominal palpation and auscultation.

In twin conception, on uncovering the woman's abdomen, one can at once notice the considerable dimensions of the uterus, the irregularity of its shape, a depression, even a sulcus, crossing obliquely the abdominal walls.

This sulcus is always present when the two fœtuses are lying obliquely above the other, as generally happens. But it does not exist when the fœtuses are one in front of the other.

By abdominal palpation, the diagnosis is easy in the first instance, but difficult in the other instance.

At any rate, palpation at once reveals the great volume of the uterus and its irregular shape. But its tension, on account of a greater amount of amniotic fluid, renders the diagnosis more difficult, as the fœtal parts are not so well defined.

By palpation it can be ascertained that in twin pregnacy the large fœtal tumors are double; for instance, one head can be found near the superior strait, the other at the fundus of the uterus; and one back, in an oblique and inferior direction.

In other instances, there may be found two breeches, two backs, and only one head in one of the iliac fossæ; the other head, being concealed in the excavation, can be found by the vaginal touch only. This is a very delicate point in obstetric diagnosis.

Auscultation will generally much assist in ascertaining the beat of two hearts at different points.—*Boisliniere American Gynecological Journal.*

Report of Five Cases of Alexander's Operation.—Cugiani (*Annales de Gynecologie et d' Obstetrique*, vol. xxxix., 1893) reports that in one of his cases it was impossible to find the round ligament an either side. The remaining four cases resulted in perfect cures, the pain and metrorrhagia disappearing; some nervous troubles, however, persisted. Alexander's operation can be done with the best of results in cases of retroflexion, retroversion and prolapse, hysteropexy being indicated only in case of very marked prolapse. —*Therapeutic Gazette.*

Diseases of Children.

Membranous Croup.—In a paper on this subject, (*Times and Register*) Dr. R. M. Harbin expresses his preference for tracheotomy over intubation. However, as he has had no experience with the latter operation, his opinion against it is not as forceful as it otherwise would be. He gives the following excellent description of the operation of tracheotomy:

Chloroform should be given, cautiously at first, and when the patient is under its influence the neck should be scrubbed and cleaned, and a round wine bottle put into a stocking should be placed under the back of the neck. The hands and instruments having been treated antiseptically, the parts should be carefully mapped out.

Of the two operations, superior and inferior, the superior has the preference, as the trachea is nearer the surface and the operation is more easily done. The ring of the cricoid cartilage should be sought for and an incision about three-fourths inch long should be made from this point downward. Haste will make the operation more difficult.

After making the incision through the skin the dissection should be done with the point or handle of scalpel When the lobe of the thyroid gland is reached it should be pushed aside. At every step the finger should be used freely as a guide to the position of the parts. I prefer ragged edged to clean cut incisions, as hæmorrhage will be less likely to occur.

When the dissection has reached the trachea, hæmorrhage having been checked, the trachea should be opened from below upward, which, when done, is indicated by bubbles of air. The wound should be sponged constantly. An aneurism needle may be introduced into tracheal wound and will facilitate introduction of the tube. When the tube is *in situ* there is immense relief to both patient and surgeon, the little sufferer sinking into a restful slumber for ten to twelve hours, being disturbed only by cough and expectoration. A feather should be introduced occasionally into the tube and trachea to stimulate cough and expectoration. The tube should be secured with tapes around the neck, and iodoform dusted upon the wound.

Diphtheritic Hemiplegia.—In a recent number of the *Neurologisches Centralblatt* Dr. Donath of Buda-Pest has published a case of diphtheritic hemiplegia. The patient was a boy eight years old, a peasant's son with healthy parents, who suffered from an attack of diphtheria which lasted fourteen days. On the third day of his convalescence, when he was beginning to get about, he was seized in the nighttime with an attack of hemiplegia affecting the whole of the right side of the body, including the face, and also giving rise to loss of speech. During fourteen days this loss was complete; he could not, according to his mother's account, utter a word, but made himself understood by gestures. He was able to understand all that was said to him. The paralysis, so far as it affected the face, began to pass off in three weeks, and the aphasia to improve in four weeks. When he began to speak, he could only do so in a whisper, but there was no difficulty in swallowing. Two months later, when Dr. Donath first saw him, there was no further improvement evident in speech, face or limbs. There was a well marked weakness of the right side of the body, affecting the face, arm, and leg; the speech was strong, but rather stammering and indistinct. There was some contracture in the right arm, and the corresponding leg was dragged in walking. There was slight general wasting of the affected limbs, but the electrical reactions were normal, and there was no impairment of sensibility.

The myotatic irritability in the affected limbs was much increased. Under observation there was slight improvement. In his comments on the case, Dr. Donath directs attention to the rarity of hemiplegic diphtheritic paralysis, and in support of this quotes Dr. Gowers to the effect that "the weakness of the extremities in this disease is gradual in its onset, seldom or never absolute, and as a rule symmetrical, while distinct hemiplegic weakness is never observed." We venture to think that the case here recorded is no exception to this rule. Of course, it all depends on what constitutes diphtheritic paralysis, strictly so-called. There is no doubt that Dr. Gowers has not stated that hemiplegia following diphtheria never occurs, and what he evidently means in the statement quoted is that diphtheritic paralysis, the paralysis produced by the action of the diphtheritic poison, or some product of it, on the nervous system, never affects one half of the body. The occurrence of a hemiplegia, which is evidently the result of a cerebral lesion, whether thrombotic, embolic, or hæmorrhagic, after diphtheria is evidently quite compatible with this statement, as it is a condition essentially different, and we think it is misleading that any such case should be described or regarded as an instance of post-diphtheritic paralysis.—*Lancet.*

Post Nasal Growths in Children. — He read before the Harveian Society of London a paper on post-nasal growths in children, and showed two children with widely cleft palates in whose throats the normal pharyngeal tonsil could be clearly seen. He spoke of the close analogy which existed between the pharyngeal tonsil and the other lymphoid elements of the naso-pharynx and the faucial tonsils, both as regards structure and hypertrophy. He considered the association of tubercle and adenoids exceptional, though hypertrophy of the lymphoid structures was often found in feeble children. As regards the diagnosis, he thought that the long and vacant looking face, the open mouth, the thin and compressed nostrils, and inability of the child to breathe through the nose and the "stuffy" and dead voice were more than enough to establish proof of the disease. By curling the index finger round the soft palate the vegetation could be felt in the naso-pharyngeal cavity. In children at least, posterior rhinoscopy was unnecessary. He urged the prompt removal of the hypertrophied tissue; otherwise recurrent attacks of difficulty of hearing and permanent deafness might ensue. Such children were said to become afflicted with aprosexia," a term which had doubtless been invented to denote the existence of some grave defect, but of the exact meaning of the word he was ignorant. He invariably operated in these cases under chloroform, and thought it important not to have the children deeply narcotized. He considered that in no operation was it more needful to have a competent anæsthetist than in this. The children were placed upon their backs with the shoulders raised, and the head hanging over the end of the table. Though he found that for children the finger nail usually sufficed, he sometimes found it necessary to use Löwenberg's forceps, or a sharp spoon. As regards the aftertreatment, he kept the children lying quiet for awhile, and did not even bother them with nasal douches. Though the operation was not without danger, it entailed no great risk. He gave particulars of one fatal case which had occurred in the practice of a friend of his, who was an accomplished surgeon and skillful operator. He thought that all such disasters ought unhesitatingly to be recorded.—*Arch. of Pediat.* (*Brit. Med. Journ.*)

Toxicology.

Two Cases of Cocaine Susceptibility.—No. 1. Young man, florid, stoutly built, healthy and robust, farmer. Operation for stricture of lachrymal duct. Had used about one-half of the contents of small dropper, which held about thirty-five drops of four per cent cocaine solution. While waiting a moment attention was called to the patient by his drawing a deep, sighing respiration, then falling to the floor in a dead faint. Gave half glass of whisky, and in a few moments he recovered, but was in a dazed condition for half an hour.

No. 2. Young lady, actress, delicate, anæmic looking girl, suffering from an attack of acute tonsilitis. Sprayed about fifteen drops of a two per cent solution on tonsils and pharynx, preparatory to the application of a thirty-grain solution of nitrate of silver to the tonsils. Patient immediately suffered great distress, evinced by difficulty of breathing, and said she felt that she was "smothering to death." Gave her a glass of sherry, and made application to tonsils.

She appeared to get all right, but upon walking to waiting room fell in a faint. Gave another glass of sherry, bathed face with ice water, and in a few moments she recovered sufficiently to go home, but was quite ill and nervous for eight or ten hours afterward.—George Brown, in *Atlanta Medical and Surgical Journal.*

Hydrastinine.—Wild reports several accidents due to the administration of this drug, particularly in the pharyngeal region. He describes the case of a female patient, aged thirty-nine years, who was suffering from uterine hæmorrhages, which persisted in spite of all the usual remedies having been tried. The author conceived the idea of using hydrastinine, and gave her subcutaneous injections of a 10-per-cent solution of hydrastinine. At each injection one cubic centimetre was given, containing 10 centigrammes of the remedy. Seventeen injections were given in forty days. At the moment of the last injection the patient complained of a violent pain in her neck. An examination revealed the presence of limited patches, having a very apparent projection of about two millimetres. During the following days these patches became much larger and of greater prominence, and the mucous membrane surrounding them became much inflamed. The pain in the neck increased, extending to the ears, and entirely prevented alimentation, as the act of swallowing caused such intense pain. Dr. Wild suspected that the hydrastinine was the cause of these symptoms, and, in order to make sure, he, after several days, gave another injection of the drug. The following day the same phenomena occurred with the same intensity. The author does not hesitate to attribute these symptoms to the intoxication caused by the hydrastinine; they are analogous to those produced by the abuse of atropine, and which, no doubt, originate from paralysis of the secretory nerves. It is, therefore, a remedy whose effects should always be carefully watched, and care should be taken to examine the throats of patients treated by hydrastinine.—*Deutsche medizinische Wochenschrift, Universal Med. Jour.*

Rhinology and Larynology.

COCAINE AND MENTHOL IN HAY FEVER.—In the discussion on the treatment of hay fever at the meeting of the Pan-American Medical Congress, *Journal* A. M. A., Dr. J. N. Mackenzie said:

I have long since given up cocaine in the treatment of this disease, except as a purely palliative measure. At a meeting of the Laryngological Association some years ago, in Detroit, I called attention to the fact, shortly after the drug was brought over to this country, that the time came sooner or later when cocaine dilated the blood vessels in the mucous membrane of the throat and nasal passages, and I think that point is now perfectly well established, and Dr. Delavan's denunciation of its indiscriminate use is correct. But there is another point not generally known, namely, the evil effect menthol sometimes produces. I know of two cases in the practice of a fellow practitioner in which menthol has given rise to brain symptoms similar to those cocaine produces. They were both singers, and had learned that a little menthol squirted into the nose with an eye dropper just before they were going to sing would make their voices more resonant, so it had become their practice every time they were to sing to drop in a little of this seemingly harmless thing, and finally the friends of one of them noticed that she was having hallucinations and that her mind was becoming otherwise affected. This was spoken of to a physician, and when she ceased taking the menthol all her bad symptoms disappeared. The other case was affected in the same way, and on discontinuing the use of menthol became well again.

RHINITIS ATROPHICA FETIDA.—Dr. O. M. Waterman read a paper on this subject at the annual meeting of the Am. Med. Association, *Journal A. M. A.*, and presented these conclusions:

1. Our knowledge of the etiology of genuine ozena is quite incomplete, and none of the hypotheses offered can be accepted unconditionally.

2. A so-called ozena syphilitica, ozena tuberculosa or ozena scrofulosa cannot be brought into the same category with ozena genuina.

3. While the atrophy in ozena genuina is preceded by a hypertrophic condition, this hypertrophy is not the ordinary rhinitis hypertrophica chronica.

4. The cause of rhinitis atrophica fetida is neurotrophic alterations of certain peripheral nerve ends, sensitive and vasomotoric.

5. The formation of crusts is caused by the change of ciliated cylinder epithelium into pavement epithelium, after the secretory glands have suffered by neurotrophic disturbances.

6. The origin of the fetor is to be found in the disintegration of the strongly albuminous secretion, which is exposed to the microörganism in the atmospheric air, the secretion acting as a foreign body on the altered mucous membrane.

7. No therapeutic attempt to cure rhinitis atrophica fetida is considered absolutely successful, but cauterizations are to be condemned.

8. The leading principle in treating the disease is vibratory massage, this promising the best results obtainable.

9. Peroxide of hydrogen is strongly recommended as a remedy at once stimulant, disinfectant and non-irritant.

10, 11 Loan Trust Building.

Materia Medica.

MALACINE.—*Les Nouveaux remèdes* for October contains an article relating to this new drug. Dr. A. Jaquet, of Bale, has made a study of the therapeutic and physiological action of malacine, and finds it an excellent remedy in rheumatism and neuralgic affections. As an antipyretic it is superior to any other of the preparations of this series. It is especially suitable to protracted febrile conditions where it is essential that the remedy shall not be depressing. It is derived from the salicylate of phenacetin. It appears in small crystals of a pale yellowish color, insoluble in water, but soluble in warm alcohol. The stomach will retain the medicament when no other drug can be borne. It is particularly indicated in cases where the temperature is high and the heart much enfeebled. In rheumatism it can be given almost indiscriminately for a long period without any untoward results. In the treatment of habitual headache the remedy can be prescribed without regard to idiosyncrasies. The dose is from twenty to thirty grains, and the physiological effect continues for about six hours.—*N. Y. Med. Journ.*

PILOCARPINE.—The following, from the *Australian Med. Gazette*, is Dr. Hirschfeld's experience with pilocarpine in diphtheria. The original formula advised by Guttmau for a child about five years of age was:

℞ Pilocarpin, hydrchlor.....gr. ss
Pepsin.....gr. x
Acid, hydrochlor.....♏ ij
Aquæ, q. s.....ad. ℥ xxij
M. Sig.—A teaspoonful every hour.

But in the majority of cases it is not necessary to administer as much pilocarpine as recommended above, though children bear the drug comparatively better than grown-up people. The individual susceptibility to the alkaloid varies to a very great extent, and it is far better to feel one's way by beginning with small doses, and only increasing them if they prove insufficient in attaining the result desired—namely perspiration and salivation. It will thus be possible to avoid in nearly all cases the ill effects reported by other authors who employed too large doses at the beginning. It is advisable to combine every dose of pilocarpine with some alcohol to counteract any depressing effects and to correct the taste with syrup of orange, which generally proves agreeable to the little patients. Thus for a child six years old:

℞ Pilocarpine.....gr. ½
Spt. vin. gall.....℥ iv
Syr. aurant.....℥ j
Aquæ, q. s.....℥ iij

M. Sig.—One teaspoonful every two hours.

As a rule this will be sufficient for the purpose. If not, it can readily be increased and taken every hour. The action of the medicine is generally very satisfactory. The physiological effects of the pilocarpine—sweating and salivation—begin to show themselves sooner or later, according to the individual susceptibility to the drug, generally within twelve hours. The temperature goes down as soon as perspiration has fairly set in, while the casting off of the false membrane often takes place in surprisingly quick time. It is not advisable to discontinue the pilocarpine at once, but break it off gradually.—*Medical Summary.*

ICHTHYOL.—Dr. H. A. Hare, in *Therapeutic Gazette*, says that "ichthyol is a remedy which, by comparison, is as new as cantharides is old, yet its great value in a very wide range of cases is so well recognized that it is largely used. Its use has been to a great extent practically empirical, since even now we scarcely know more of it than that it acts differently from all compounds containing sulphur. So far, it seems probable that the wonderful power of ichthyol in dispersing indurations and swellings depends upon its power of dissolving the intercellular cement substance, and so setting free newly-formed cells, so that they are readily dispersed. Whatever the explanation of its action may be, it will give good results both when applied to acute and inflammatory processes. An ichthyol dressing of twenty-five per cent ichthyol and seventy-five per cent lanolin, in cases of erysipelas is the best application by long odds with which I am acquainted, and in acute articular rheumatism forms the most efficient application for the relief of the heat, swelling, redness and pain. In this disease as strong an ointment as fifty per cent is often better than one of twenty-five per cent. After it is applied, the affected part should be wrapped in patent lint heavily smeared with the same mixture. From its use in a large number of cases of acute rheumatism, I have learned to regard it as a remedy almost as valuable as the salicylates. For the purpose of relieving indurated glands, as after bubo or cervical adenitis, or the limbering up of the sheaths of muscles stiffened by strain, cold or rheumatic tendency, ichthyol has certainly a most important place. Similarly, I have frequently seen ichthyol remove obstinate skin affections either when they were dry, superficial and scaly, or when, through chronic eczema, marked subdermal induration arrested the healing process.—*Med. Summary.*

Diseases of Women.

ERGOT AT THE COMPLETION OF LABOR.—In an editorial on this subject in the *Medical Summary* the good effects of this drug are thus happily epitomized:

It is true that many of the best and most successful physicians and obstetricians have the habit of giving a dose of ergot as soon as secundines have been expelled. To them for years it has been an arm of precision; and among the agents of the materia medica there is, for them, nothing superior in the meritorious qualities of energy and reliableness.

That ergot has the power to arrest hæmorrhage from the uterus needs no proof. Would it therefore be saying too much that that power exercised on the recently emptied and fatigued womb is beneficent and productive of only good results? Results of experience, as far as collected, seem conclusive that harmful effects are not to be expected. It might be urged that Crede's method of compression, where ergot has also been given, might be depended on to account for fewer instances of post-partum hæmorrhage.

Instances without number can be recalled where patients were well-nigh moribund from loss of blood, yet hypodermics of ergotine were promptly efficient in controlling the flow—some of these occurring post-partum, some at the approach of the menopause.

As far as known there is not a recorded instance where ergot given post-partum to secure and maintain a moderate degree of contraction has been productive of hurtful effects. Therefore, may it not be concluded that used as above described, ergot does no harm and may be the means in any case of anticipating a frightful complication.

Physiology.

THE AUDITORY CENTERS IN RELATION TO LANGUAGE.—Giampietro, of Naples (*Ann. des Mal. de l'Oreille*, etc., March 1893), enumerates these centers as follows: 1. Sensory bulbar center, the destruction of which leads to total peripheral deafness, and it occurs before the age of two or three years, to irreparable aphasia. 2. Mnemonicovolitional center in the optic thalamus, on which depends the faculty of attention necessary for rational speech or writing; a vasomotor disturbance in this is the cause of transitory amnesia. 3. Ideophonic center in the first temporal convolution (left?). When this is diseased the patient, though hearing words, is unable to affix to them or remember the idea they normally convey—"*surdité verbale*" (Charcot), "ideophonic amnesia" (Giampietro). 4. Ideomotor center in the third left frontal convolution, for the remembrance of the movements necessary for the pronunciation of words, its disease causing typical motor aphasia. 5. Ideographic center at the extremity of the second left frontal convolution, disease of which results in agraphia.—*British Medical Journal.—Alienist & Neural.*

BOOK REVIEWS.

"Asiatic Cholera: Its Genesis, Ætiological Factors, Clinica History, Pathology, and Treatment." By John A. Benson, M D., Professor of Physiology and Associated Chief of the Department of Clinical Medicine, College of Physicians and Surgeons of Chicago, Illinois. 12mo, 175 pages, illustrated profusely. Cloth $2.00. A thorough and complete treatise on thi subject will be published by J. Harrison White, Chicago, 1893.

This volume comprises lectures which were delivered to the students at the College of Physicians and Surgeons in the City of Chicago, in connection with the course on the Practice of Medicine. The subject matter has been compiled from a great number of sources, and with the author's own studies in the laboratory and elsewhere, he has given to the student and graduate a work, that would prove of value, should the profession in this country ever be called upon to manage an epidemic of Asiatic cholera. The work is well and fully illustrated.

"Modern Gynecology. A Treatise on Diseases of Women."—Comprising the Results of the Latest Investigations and Treatment of this Branch of Medical Science. By Charles H. Bushong, M. D., Assistant Gynecologist to the Demilt Dispensary of New York, formerly Attending Physician to the Northern Dispensary and Assistant to the Vanderbilt Clinic, College of Physicians and Surgeons, of New York. Pages, 380; 105 illustrations New York: E. B. Treat, 5 Cooper Union. Price, neatly printed on elegant paper and neatly bound in cloth, $2.75. 1893.

The already large number of works published on the subject above, and also upon diseases of women, would lead one to suppose that the subject had long ago been exhausted, but as many of them are too large for the ordinarily busy practitioner, the author has endeavored to give to the profession, a clear, common sense statemeut of the symptoms of the various diseases of the female sexual organs; to indi-

cate in detail the methods of treatment that can be applied by him, and also to indicate in brief the methods requiring the aid of a specially trained consultant of larger experience.

No efforts have been spared to make this book a valuable accession to the library of the general practitioner, as it is very complete and comprehensive, and well illustrated.

"Electr.city in Diseases of Women and Obstetrics." By Franklin H. Martin, M. D. Professor of Gynecology Post-Graduate Medical School of Chicago, Attending Surgeon to Woman's Hospital of Chicago, Gynecologist to Charity and Post-Graduate Hospitals, etc. Profusely illustrated. One handsome octavo volume; cloth. Price, $2, postpaid. Chicago: The W. T. Keener Company. 1893.

The second volume of this work, has followed rapidly on the steps of the first, being less than one year since its issue. Four new chapters have been added as follows: General Galvanization and General Faradization, The Electric Bath, Static Electrotherapeutics, and Summary of Treatment of General Diseases. The work enters into details which are of great value to students, and which knowledge they are not expected to have acquired. To the practitioner who has had a moderate amount of experience in the application of electricity to the diseases of women and in obstetric cases, the personal experience of one who has worked in so vast a field will prove of inestimable value.

"A Handbook of Local Therapeutics." General Surgery, by Richard H. Harte, M. D.; Diseases of the Skin, by Arthur Van Harlingen, M. D.; Diseases of the Ear and Air Passages, by Harrison Allen, M. D.; Diseases of the Eye by George C. Harlan, M. D. Edited by Harrison Allen, M. D. 505 pages; cloth, $4. Philadelphia: P. Blakiston, Son & Co. 1893.

The author states that as no text was available in which the local action of drugs were not subordinated to their general actions, it was decided to undertake the preparation of this work. In the lines of special medicine, as represented in General Surgery, Dermatology, Otology, Rhinology, Laryngology and Ophthalmology, the topical uses of drugs are among the most important to which they can be put, so it was thought that statements concerning them from experienced practitioners would be acceptable and of value to the profession. The drugs have been considered alphabetically to materially facilitate reference.

All pharmaceutical and chemical statements have been submitted to rigid scrutiny, and the proof sheets carefully revised, so that all danger of error has been avoided. The work will undoubtedly hold a high position and be consulted many times for information that as yet cannot be found so complete in any other work.

"A Practical Treatise on Materia Medica and Therapeutics, with Especial Reference to the Clinical Application of Drugs." By John V. Shoemaker, A. M., M. D., Professor of Materia Medica, Pharmacology, Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico Chirurical College of Philadelphia; Physician to the Medico-Chirurgical Hospital; Member of the American Medical Association, of the Pennsylvania and Minnesota State Medical Societies, the American Academy of Medicine, the British Medical Association; Fellow of the Medical Society of London, etc. Second edition. Revised. In two royal octavo volumes. Volume I., 353 pages; devoted to Pharmacy, General Pharmacology and Therapeutics and Remedial Agents not Properly classed with drugs. Volume II., 680 pages; An independent volume upon drugs. Volume I, in cloth, $2 50 net; Sheep, $3 25 net. Volume II, in cloth, $3.50 net; Sheep, $4 50 net. Philadelphia: The F. A Davis Company, Publishers, 1914 and 1916 Cherry Street.

This practical treatise needs but little praise from the reviewer. That a second edition of the work has become necessary shows the appreciation at the hands of the medical profession. The author is well known and highly esteemed for his writings and lectures, and in this revised edition has taken the opportunity to make additions and alterations representing the clinical investigations relative to certain remedies which have been recently introduced. Brief accounts will be found in the book of trichloracetic acid, cantharidate of potassium, euphorin, europhen, phenocoll, piperazin, benzo, naphthol, losophan, methylene blue, chloralose, salophen, strontium, thallin and many other substances. The section upon tuberculin has been revised to correspond with the experience of later date.

Many text-books appear on the subject of Materia Medica and Therapeutics, but we know of none that are so popular with the medical profession throughout this and foreign countries as the works of this author.

"The Bacterial Poisons." By Dr. N. Gamaleia. Translated by E. P. Hurd, M. D. Member of the Massachusetts Medical Society, and of the Climatological Society; one of the Physicians to the Newburyport (Mass.) Hospital. George S. Davis. 1893.

This number of the Physicians' Leisure Library is of interest on account of bacterial poisons for the first time being made the subject of a connected treatise. The work is divided into three parts, the first embracing History of Microbial Toxicology, and describing the evolution which the study of systemic poisoning in the infection has undergone. The second part—General Toxicology—treats of actual information respecting the chemical nature of the microbial poisons, their production, and their destiny in the animal body. The third part, or Special Toxicology, is the exposition of the date acquired concerning the toxines of different diseases.

MISCELLANEOUS.

THE FREQUENCY OF GONOREHŒA AMONG PROSTITUTES.—Buettner (Abst. in *Fort. a Med.*, 11, 15) has been examining the prostitutes of Dorpat for gonococci. Out of fifty-four only forty-eight per cent, showed gonococci in vagina. Of these fifty-four, twenty-two were being treated in the hospital for other troubles, and gave opportunity for repeated microscopical examination; of these only five showed microscopical signs of gonorrhœa, while seventeen (sixty-eight per cent) showed gonococci with the microscope.—*Omaha Clinic.*

AN AGREEABLE MENU FOR THE CORPULENT.—*Breakfast* (summer, 7; winter, 8): Eight ounces black tea or coffee, without milk, and sweetened with saccharin; two ounces white bread crust or toast, or Italian bread, with butter; some boiled fish or two eggs.

Luncheon (at 12:30): Two large unpeeled apples.

Dinner (at 2 P. M.): One large unpeeled apple, followed by some white fish; one-quarter of a pound roast or boiled meat, or moderately fat bacon; spinach or salad plentifully; vegetables, except potatoes and beans, in moderate quantity; half ounce crust of bread, toast or Italian bread; moderate quantity of

raw or stewed fruit, sweetened with saccharin (or a little bicarbonate soda added to the water to neutralize the acid); six to eight ounces light wine; dessert, lemon ice, sweetened with saccharin.

Supper (at 6:30 P. M.): Four ounces tea or coffee or beef tea; an egg; bit of cold ham, not fat; four ounces bread crust or toast, with butter; a little cheese or fresh fruit.—*Jour. of Bolneol.*

ANCIENT CATHETER.—Doctor J. W. S. Gauley exhibited to the New York State Medical Society, at its last meeting, a catheter found at Pompeii. It is of copper, covered with verdigris, of sigmoid form, and with the vesical opening near the extremity. Similar catheters will be found described by Celsus, and the rules which he gives for introduction are by no means obsolete to our own day.—*Medical Age.*

AN ANATOMICAL CRITERION TO DISTINGUISH MALE FROM FEMALE SKULLS.—Prof. Virchow declared two years ago that all the alleged modes of differentiation so far recommended were worthless, but Dr. Thiem Cottbus (*Arch f. Klinieche Chirurgie*, Bd. 37) lately described what seems a satisfactory craniological criterion of sex.

The os tympanicum forms part of the posterior wall of the glenoid cavity of the inferior maxillary, and also closes in front and below the bony meatus of the ear. It arises perpendicularly from the petrous portion of the temporal bone posteriorly, and turns backward in the woman, at about half the height of the mastoid process, but in the man at a less height. In the male, the bone develops a sharp edge, which divides to form the sheath of the styloid process; but in woman this sharpened edge does not exist, the bone is rounded into a tubercular form, and the fossa is shallower and flatter.

Thus in the male this fossa-tympanico stylo-mastoida is small, and the posterior wall of the glenoid cavity extends so deep that it is not possible for the condyloid process to slip over it. In the female, it is so much more spacious that this feature alone will serve to distinguish the crania of one sex from the other; and it also explains the surgical fact that laxation backward of the inferior maxillary is observed only in women.—*Med. Times, N. Y.*

A SURGEON'S NERVE.—The following is from a recent article in *Longman's Magazine*: "It is the common belief that a surgeon must possess what is spoken of as an extraordinary good nerve, and you may perhaps doubt if you possess this. At the same time you must bear in mind that in the case of a surgeon the coolness or calmness which is so admirable and necessary in an operation does not imply the possession of any remarkable personal quality, but it is the simplest result of a complete knowledge of what he is doing. It is rather the natural outcome of his accurate familiarity of anatomy, and his daily habit. A trooper would require a very fine nerve to go to a masthead, or a sailor to ride an unmanageable horse across a country, but a sailor's confidence aloft is due more to a matter of habit than to any particular amount of courage. In saying this, I do not wish to depreciate the calmness of the surgeon in the face of difficulties, but I may tell you quite plainly that if you haven't enough courage to be a surgeon I should be very much ashamed of you, and you would turn out to be a very poor creature, whatever occupation you might follow. Still this fact remains, and you may perhaps be interested to hear that I, who have known many good surgeons, have never seen one who has not possessed a very fine courage. In short, a very good surgeon is, in my humble opinion, a very fine fellow, and when I see (as I do see) the extraordinary achievements of modern surgery, I am very proud of belonging to a profession which has made life so much more endurable and prolonged to the human race. So, possibly, the great fascination which surgery no doubt possesses to many, appeals more strongly to men of courage and determination than to those persons of more weakly constituted minds, or to those who are less vertebrate altogether."—*N. Y. Med. Journal.*

KEELEY VS. THE "MEDICAL PRESS AND CIRCULAR."—We have peculiar satisfaction in informing our readers that, as we anticipated, the action for libel commenced by Dr. Keeley against the *Medical Press and Circular* some months ago has collapsed, in explanation of which we publish herewith a letter from the plaintiff's solicitors. The satisfaction which we feel is not due to the release from pecuniary liabilities, but to the fact that we fearlessly expressed ourselves, honestly and without prejudice, respecting a matter of grave importance to the public and of no small concern to the profession. The course which we took was so far distasteful to Dr. Keeley that proceedings for libel were commenced against us. Nevertheless we refused to retract or apologize for the statements which had given offense. As a representative organ of the medical profession, it has always been the endeavor of the *Medical Press and Circular* to uphold the honor and reputation of the profession, and at the same time to guard the public, and it was, therefore, in the fulfillment of this sense of duty that we decided to defend the action which had been brought against us. The following is a copy of the letter:

"The demands upon Dr. Keeley's time and attention in America are so great that, as already deposed to in his affidavit, he finds it absolutely impossible to come to England at present. After the expression of the judges in the Divisional Court he feels that his absence, though enforced, would be misconstrued, and with very great regret he is consequently compelled to adopt the only alternative opened to him to discontinue the action against the *Medical Press* as well as the action against the *Lancet*. Dr. Keeley feels that the decision he has come to is right, having regard to his public duty, and he can only trust that time and events will satisfy his critics in this country that they have done him an injustice in circulating the reports complained of.

"We are about to take the necessary steps to discontinue both actions, but we think it right to give you this intimation immediately. It will follow as a matter of course that the costs of the respective proceedings will have to be paid by Dr. Keeley and this we need not say will be done immediately the amount is ascertained; you will remember that there is already the sum of £119 10s. in court, paid in by us on Dr. Keeley's behalf to security for costs account."—*Med. Press and Circular.—Lancet-Clinic.*

Dr. Sutherland claims to have found a marked uric acid diathesis in all cases of appendicitis in children.

Dr. Walter May Rew, of New York, whose bogus medical college was exposed last July, was sentenced October 10 to three months' imprisonment in the penitentiary.

Stamina the Best Prophylactic.—In the Institute of Experimental pathology in Vienna, Professors Hasterlik and Stockmayer, four students and others, swallowed a quantity of comma bacilli. They suffered no bad effects beyond headache and nausea. Professor Stricker therefore draws the conclusion that the comma bacilli will not cause cholera in the case of strong, healthy subjects.—*Sanitarian.*

Dr. Ernest Hart on Chicago.—This eminent visitor has written for the *British Medical Journal* his impressions of American medicine, and among other things has the following to say of Chicago:

"Chicago is laying wide and deep the foundations of its literary and scientific civilization. Two great and richly endowed libraries—one with a limitless supply of medical literature—are already endowed with munificent incomes. The Rush College is of ancient fame, but is being largely extended; the Armour Institute and the Chicago University are springing into great efficiency and importance. Chicago has one of the best, if not the best, schools of pharmacy in America. Three thousand college students already throng her gates, and the munificence of her citizens is fast supplying them with solid and complete means of study and incitement to research.

Infection.—The period of infectiousness of contagious diseases, according to the State Health Board of Pennsylvania, is:

Small pox—Six weeks from the commencement of the disease, if every scab has fallen off.

Chicken-pox—Three weeks from the commencement of the disease, if every scab has fallen off.

Scarlet Fever—Six weeks from the commencement of the disease, if the peeling has ceased and there is no sore nose.

Diphtheria—Six weeks from the commencement of the disease, if sore throat and other signs of the disease have disappeared.

Measles—Three weeks from the commencement of the disease, if all rash and the cough has ceased.

Mumps—Three weeks from the commencement of the disease, if all swelling has subsided.

Typhus—Four weeks from the commencement of the disease, if strength is reëstablished.

Typhoid—Six weeks from the commencement of the disease, if strength is reëstablished.

Whooping Cough—Six weeks from the commencement of the disease, if all cough has ceased.

Under judicious treatment the period of infectiousness may be considerably shortened, but no child suffering as above should be admitted to any school after a shorter period of absence, and then should be provided with a medical certificate, that he or she is not liable to communicate the disease.

Length of quarantine.—Teachers or children who have been exposed to infection from any of the following diseases may safely be readmitted to the school, if they remain in good health (and have taken proper means for disinfection) after the following periods of quarantine:

Diphtheria, 12 days; scarlet fever, 14 days; smallpox, 18 days; measles, 18 days; chicken-pox, 18 days, mumps, 24 days; whooping cough, 21 days.

Adults may be readmitted immediately, if they disinfect their clothes and persons.—*Maryland Med. Jour.*

In the Swim.—According to the newspapers, Dr. Judson Daland, of Philadelphia, recently swam the Strait of Messina, known to the ancients as the whirlpool between Scylia and Charybdis. This feat is said not to have been accomplished before within the memory of the oldest inhabitant of Faro, a neighboring fishing village. Dr. Daland is reported to have said: "The entire swim was made without rest or stimulants, and I restricted myself to the breast and side stroke, not using the back at all. I encountered during the swim strong currents, running apparently in all directions, the direction changing every few moments. These currents were at times warm and at others icy cold. There was a high wind and a choppy sea, making it extremely difficult to breathe. I returned to Messina in good condition, and that same evening went to the opera."—*N. Y. Medical Journal.*

Problems of Public Interest Concerning the Insane.—In a paper thus entitled, read by Dr. Orpheus Everts, of College Hill, Ohio, at the recent meeting of the Mississippi Valley Medical Association, he said there were several problems of public interest involved in the present relations of society to the insane. Among the more important of them were questions of dependency and curability of the insane and the preventability of insanity. The author summarized his conclusions as follows:

1. Intelligent provision for the insane implies provision for various classes, according to the capabilities of enjoyment and the exercise of various impaired faculties.

2. Public provision for whatever class of insane persons implies housing, clothing, food, sanitary and moral discipline, amusement and employment for such as are capable of being amused and employed, and medical treatment for the sick. The essential features of such provision are adaptability to the needs of each distinctive class.

3. Great, expensive, architecturally imposing palaces, providing alike for all classes, however serviceable they may have been, æsthetically considered, in times past, as they unquestionably were, are no longer necessary or appropriate to the needs indicated. So long as the insane are comfortably housed, each class according to its condition, it is comparatively unimportant whether it be in large or small houses, cottages or palaces, connected or detached, in high or low buildings.

4. It is important that the insane of all classes be well fed under careful supervision; but whether in small or large dining rooms, by groups or congregations, is of little consequence; it should be a matter of convenience rather than of number.

5. It is important that public institutions for the insane be well organized and administered.

6. It is wise to retain in office capable men, who have demonstrated their fitness by successful management of affairs, so long as their capabilities continue to be elastic.—*Memphis Medical Monthly.*

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